CHAPTER 4: COMPETITION LAW: HOSPITALS

CHAPTER 4: COMPETITION LAW: HOSPITALS

I. INTRODUCTION

Analyses of the likely competitive effects of hospital mergers have been an important part of antitrust enforcement since the FTC issued its first hospital merger complaint in 1981.[1] Most hospital mergers and acquisitions do not present competitive concerns.[2] The *Department of Justice and Federal Trade Commission Statements of Antitrust Enforcement Policy in Health Care* (*Health Care Statements*) specifically set forth a safety zone for hospital mergers that will be rarely (if ever) challenged by the Agencies.[3] Indeed, since 1981, the Commission and DOJ have challenged relatively few hospital mergers, in some instances seeking relief only for part of the transaction.[4] The Agencies have used consent orders to resolve competitive concerns about several of these mergers.[5]

Nonetheless, the Agencies have found some hospital mergers likely to have anticompetitive effects and had considerable early success in litigating hospital merger cases.[6] From 1994 through 2000, however, when there were approximately 900 hospital mergers, the

---

[1] Am. Med. Int'l v. FTC, 104 F.T.C. 1 (1984), *as modified by* 104 F.T.C. 617 (1984) and 107 F.T.C. 310 (1986). The Commission decision held that a for-profit hospital chain's acquisition of a competing hospital in the city and county of San Luis, Obispo, California, violated § 7 of the Clayton Act and § 5 of the FTC Act. The Commission found that the acquisition lessened both price and nonprice competition, and ordered divestiture of the acquired hospital.

[2] U.S. DEP'T OF JUSTICE & FEDERAL TRADE COMM'N, ANTITRUST ENFORCEMENT POLICY STATEMENTS IN THE HEALTH CARE AREA § 1 (1996) [hereinafter HEALTH CARE STATEMENTS], *available at* http://www.ftc.gov/reports/hlth3s.pdf. Agency review of most proposed hospital mergers is typically completed in less than a month. *Id*. § 1. *See also* J. Jacobs 3/28 at 69.

[3] HEALTH CARE STATEMENTS, *supra* note 2, § 1. The safety zone encompasses mergers between two general acute-care hospitals "where one of the hospitals (1) has an average of fewer than 100 licensed beds over the three most recent years, and (2) has an average daily inpatient census of fewer than 40 patients over the three most recent years, absent extraordinary circumstances." *Id*. This safety zone does not necessarily apply if one of the hospitals is less than five years old. Transactions that fall outside the safety zone are not necessarily anticompetitive and may be pro-competitive.

[4] The Agencies challenge relatively few mergers overall. In 2001, the Agencies were notified of 2,376 total mergers (the FTC challenged 23 and DOJ challenged 32) and a few of those were below the thresholds for notification. FEDERAL TRADE COMM'N STAFF, U.S. DEPARTMENT OF JUSTICE, ANTITRUST DIVISION, ANNUAL REPORT TO CONGRESS, FISCAL YEAR 2002 (2003), *available at* http://www.ftc.gov/os/2003/08/hsrannualreport.pdf.

[5] *See* HEALTH CARE SERVICES & PRODUCTS DIVISION, FEDERAL TRADE COMM'N, FTC ANTITRUST ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS (2003), *available at* http://www.ftc.gov/bc/hcupdate 031024.pdf; U.S. Dep't of Justice Antitrust Division, *Health Care Task Force: Recent Enforcement Actions*, *at* http://www.usdoj.gov/atr/public/ health_care/2044.htm; U.S. Dep't of Justice Antitrust Division *Summary of Antitrust Division Health Care Cases Since August 25, 1983*, *at* http://www.usdoj. gov/atr/public/ health_care/0000.pdf.

[6] Martin Gaynor & William B. Vogt, *Competition Among Hospitals*, 34 RAND J. ECON. 764, 764 (2003).

Agencies and state antitrust enforcers lost all seven cases they litigated.[7] Some scholars have strongly criticized the courts' reasoning in these cases.[8]

The Agencies analyze hospital mergers using the same analytical framework they use for other mergers. The *1992 Horizontal Merger Guidelines* (*Merger Guidelines*) specify that "mergers should not be permitted to create or enhance market power or to facilitate its exercise."[9] Market power "is the ability profitably to maintain prices above competitive levels for a significant period of time."[10] A merger also may "lessen competition on dimensions other than price, such as product quality, service, or innovation."[11]

---

[7] *Id*. at 764. The seven cases were: California v. Sutter Health Sys., 84 F. Supp. 2d 1057 (N.D. Cal.), *aff'd mem.*, 2000-1 Trade Cas. (CCH) ¶ 87,665 (9th Cir. 2000), *revised*, 130 F. Supp. 2d 1109 (N.D. Cal. 2001); FTC v. Tenet Healthcare Corp., 17 F. Supp. 2d 937 (E.D. Mo. 1998), *rev'd* 186 F.3d 1045 (8th Cir. 1999); United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121 (E.D.N.Y. 1997); FTC v. Butterworth Health Corp., 946 F. Supp. 1285, 1300-1301 (W.D. Mich. 1996), *aff'd*, 1997-2 Trade Cas. (CCH) ¶ 71,863, 71,867-68 (6th Cir. 1997); United States v. Mercy Health Services, 902 F. Supp. 968 (N.D. Iowa 1995), *vacated as moot*, 107 F.3d 632 (8th Cir. 1997); FTC v. Freeman Hosp., 911 F. Supp. 1213 (W.D. Mo.), *aff'd*, 69 F.3d 260 (8th Cir. 1995); *In re* Adventist Health Sys., 117 F.T.C. 224 (1994). One of the seven cases was brought by state antitrust enforcers without either Agency's involvement. *See Sutter Health Sys*., 84 F. Supp. 2d 1057.

[8] *See* Thomas L. Greaney, *Night Landings on an Aircraft Carrier: Hospital Mergers and Antitrust Law*, 23 AM. J.L. & MED. 191 (1997). As Professor Greaney notes, in *Freeman Hospital*, the FTC produced patient-origin data that showed a high percentage of patients stayed in the government's proposed geographic market, as well as forward looking testimony of market participants, including competitors, buyers, and consumers. The Court placed the Commission in a "Catch 22: hard evidence like historical patient-origin data was unacceptable because it did not address future contingencies, and managed care testimony was inadequate, although it addressed future contingencies, because it lacked the specificity of hard evidence." *Id*. at 207-08. Similarly, Professor Greaney noted that in *Mercy Health Systems*, the courts ignored most of DOJ's subjective and objective evidence designed to provide a dynamic analysis of the market and discounted opinion testimony of the most knowledgeable market participants, including third party payors and physicians. *Id*. at 209-212.

See also Peter Hammer & William Sage, *Critical Issues in Hospital Antitrust Law*, 22 HEALTH AFFAIRS 88, 90 (Nov./Dec. 2003) (noting merging hospitals have persuaded some courts "that nonprofit hospitals will not raise prices in the same manner as would for-profits or businesses outside of health care with comparable market share" and that relevant geographic markets include hospitals 70 to 100 miles away); William Sage et al., *Why Competition Law Matters to Health Care Quality*, 22 HEALTH AFFAIRS 31, 41-42 (Mar./Apr., 2003) (some courts presume nonprofit health facilities act in the public interest, and that increased revenues will be spent on quality improvements).

As the current Chairman of the Federal Trade Commission recently observed, "In hospital merger cases, the government is zero for the last seven. I don't know the specifics of every case, but what's striking is the zero. I can certainly accept the idea that the government should not have won them all. But it seems very unlikely the government should have lost them all." William M . Sage, *Protecting Competition and Consumers: A Conversation With Timothy J. Muris*, 22 HEALTH AFFAIRS 101, 103 (Nov./Dec. 2003).

[9] U.S. DEP'T OF JUSTICE & FEDERAL TRADE COMM'N, HORIZONTAL MERGER GUIDELINES § 0.1 (1992 *rev*. 1997, efficiencies section only) [hereinafter MERGER GUIDELINES], *available at* http://www.ftc.gov/bc/docs/horizmer.htm.

[10] MERGER GUIDELINES, *supra* note 9, § 0.1.

[11] *Id*. § 0.1 n.6.

To identify mergers that are likely to cause competitive problems, the *Merger Guidelines* provide for the examination of several issues, including:

- whether the merger, in light of market concentration and other factors that characterize the market, would be likely to have adverse competitive effects;

- whether entry would be timely, likely, and sufficient either to deter or to counteract the competitive effects of concern;

- whether there are efficiency gains from the merger that meet the Agencies' criteria for examination; and

- whether, but for the merger, either party to the transaction would be likely to fail, causing its assets to exit the market.[12]

Merger analysis can begin with an assessment of direct evidence of likely anticompetitive effects.[13] The Supreme Court has stated that "the finding of actual, sustained adverse effects on competition … is legally sufficient to support a finding that the challenged restraint was unreasonable even in the absence of elaborate market analysis."[14] A number of lower court decisions have followed this principle.[15]

Merger analysis also can begin with the identification of relevant product and geographic

---

[12] *Id*. § 0.2. The last factor is sometimes referred to as the "failing firm defense." As the guidelines explain:

> A merger is not likely to create or enhance market power or facilitate its exercise if the following circumstances are met: 1) the allegedly failing firm would be unable to meet its financial obligations in the near future; 2) it would not be able to reorganize successfully under Chapter 11 of the Bankruptcy Act [11 U.S.C. §§1101-1174 (1988)]; 3) it has made unsuccessful good-faith efforts to elicit reasonable alternative offers of acquisition of the assets of the failing firm that would both keep its tangible and intangible assets in the relevant market and pose a less severe danger to competition than does the proposed merger; and 4) absent the acquisition, the assets of the failing firm would exit the relevant market.

Id. § 5.1.

[13] *e.g.*, *In re* Schering-Plough Corp., No. 9297 at 16-17 (Dec. 18, 2003) (discussing FTC v. Indiana Fed'n of Dentists, 476 U.S. 447, 460-61 (1986)), *available at* http://www.ftc.gov/os/adjpro/ d9297/031218 commissionopinion.pdf.

[14] *Indiana Fed'n of Dentists*, 476 U.S. at 460-61.

[15] *See, e.g.*, Todd v. Exxon Corp., 275 F.3d 191, 206 (2d Cir. 2001) (evidence of "an actual adverse effect on competition … arguably is more direct evidence of market power than calculations of elusive market share figures"); Toys R' Us v. FTC, 221 F.3d 928, 937 (7th Cir. 2000) (market power can be proved "through direct evidence of anticompetitive effects"); United States v. Baker Hughes Inc., 908 F.2d 981, 992 (D.C. Cir. 1990) ("'Market share is just a way of estimating market power, which is the ultimate consideration,' and … '[w]hen there are better ways to estimate market power, the court should use them'" (quoting Ball Mem'l Hosp. v. Mutual Hosp. Ins., 784 F.2d 1325, 1336 (7th Cir. 1986)).).

markets. A market is defined as a product(s) and a geographic area in which it is produced or sold, such that a hypothetical profit-maximizing firm that was the only present and future producer or seller of those products in that area likely would impose at least a "small but significant and non-transitory" increase in price.[16] This market definition test is sometimes referred to as the "hypothetical monopolist" paradigm. A relevant market is a group of products and a geographic area that is no bigger than necessary to satisfy this test.[17] Analysis typically starts with a narrow area that is broadened until a price increase by the hypothetical firm would be profitable because consumers have insufficient substitution alternatives available to defeat it.[18]

Hospital merger analysis raises a number of significant issues, including how best to define the geographic and product markets, assess the prospects for entry and the likelihood and magnitude of efficiencies, and determine the relevance of a hospital's institutional status (for-profit or nonprofit). This chapter considers each of these issues, and discusses relevant case law, academic commentary and research, and testimony and written presentations from the Hearings.

Chapter 4 also addresses the role of group purchasing organizations (GPOs) for health care systems, including the extent to which GPOs act as agents of their buyer-members or as agents of the sellers that pay the GPOs' administrative fees. This section also discusses the antitrust issues GPOs may raise and the applicability of the *Health Care Statements* to those issues. Chapter 4 concludes with a brief discussion of the antitrust implications of tiering and pay-for-performance.[19]

II. GEOGRAPHIC MARKET DEFINITION

The Agencies define hospital geographic markets using the process set forth in the *Merger Guidelines*. Panelists agreed that the *Merger Guidelines* provide an appropriate framework for defining and analyzing hospital geographic markets.[20] Although there is

---

[16] MERGER GUIDELINES, *supra* note 9, § 1.0. This test further assumes that the hypothetical profit-maximizing firm is not subject to price regulation and that the terms of sale of all other products are held constant. *Id*.

[17] *Id*. § 1.0.

[18] Seth Sacher & Louis Silvia, *Antitrust Issues in Defining the Product Market for Hospital Services*, 5 INT'L J. ECON. BUS. 181, 182-83 (1998) *at* http://www.ftc.gov/ogc/healthcarehearings/docs/030326sethbsacher.pdf.

[19] *See also supra* Chapter 1.

[20] *See, e.g.*, Guerin-Calvert 3/26 at 125, 130 (suggests using the merger guidelines and the hypothetical monopolist test; "although there is a great deal that is unique and specific about health care and hospitals in particular, [the best approach for analyzing hospital industry competition and transactions is] the same kinds of principles and the same kinds of fact-intensive analysis that is used in all other industries"); Margaret E. Guerin-Calvert, *Defining Geographic Markets for Hospitals* 6-11 (3/26) (slides) [hereinafter Guerin-Calvert Presentation],

widespread agreement on the basic framework, two well-known health law scholars have written:

> [T]he law concerning hospital [geographic] market definition is in a shambles. Common sense suggests that health care, like politics, is local. In the words of Judge Richard Posner, "People want to be hospitalized near their families and homes, in hospitals in which their own – local – doctors have privileges." However, courts have stretched the geographic boundaries of markets to strip merging hospitals of market power and thereby shield them from antitrust liability.[21]

In this section, we discuss the controversies about how to define relevant geographic markets for hospitals. We discuss the use of the Elzinga-Hogarty test and critical loss analysis to define hospital geographic markets, including the views of proponents and critics. We then describe alternative analytical techniques and evidentiary sources that Hearing panelists and researchers proposed for defining hospital geographic markets. The final subsection summarizes the Agencies' conclusions and recommendations concerning geographic market definition issues. This subsection includes the conclusion that, to date, the Agencies' experience and research indicate that the Elzinga-Hogarty test is not valid or reliable in defining geographic markets in hospital merger cases.

At the outset, we note that direct evidence of anticompetitive effects may make it unnecessary to define a relevant market. For example, consummated merger cases may present opportunities to assess competitive effects without using detailed market definitions.[22]

A. Elzinga-Hogarty, Critical Loss, and the Alternatives

Since 1995, the Agencies have lost several hospital merger cases because the courts

---

at http://www.ftc.gov/ogc/health carehearings/docs/030326guerincalvert.pdf; Vistnes 3/26 at 147-148 (stating the geographic market definition "should be driven, principally if not exclusively, by the Merger Guidelines;" the key test is whether a plan could divert enough patients to a different hospital in a different region to make the price increase unprofitable); Gregory Vistnes, *Geographic Markets and Hospital Competition* 5 (3/26) (slides) [hereinafter Vistnes Presentation], *at* http://www.ftc.gov/ogc/healthcarehearings/docs/vistnes.pdf; Werden 3/26 at 201 (noting the merger guidelines' hypothetical monopolist paradigm is the right approach); Gregory Werden, *Hospital Mergers and the Hypothetical Monopolist Test* 2 (3/26) (slides) [hereinafter Werden Presentation], *at* http://www.ftc.gov/ogc/healthcarehearings/docs/werden.pdf; David Argue 3/28 at 41-42.

[21] Hammer & Sage, *supra* note 8, at 90, *citing* to United States v. Rockford Mem'l Corp., 898 F.2d 1278, 1285 (7th Cir. 1990).

[22] *See, e.g.*, Michael Vita & Seth Sacher, *The Competitive Effects of Not-For-Profit Hospital Mergers: A Case Study*, 49 J. INDUS. ECON. 63 (2001) (using a control group methodology to assess competitive effects). Here, the competitive effect of the transaction is identified by comparing the change in price at the merging hospitals to the change in price (measured over the same time period) at a set of "control" hospitals. The control hospitals are hospitals in other geographic areas that are otherwise similar to the merging hospitals. Note, however, that a price increase by itself may not be sufficient to prove anticompetitive effects.

accepted the merging parties' use of patient flow data to perform either the Elzinga-Hogarty test[23] or critical loss analysis[24] to define the geographic market much more broadly than the plaintiff Agency.[25] Commentators and panelists observed that these cases reflect judicial acceptance of implausibly large geographic markets, judicial approval of mergers that would not be permitted in any other industry, and the lessening of competition in the hospital services market.[26]

All panelists agreed that neither the parties nor the courts should use the Elzinga-Hogarty test as the sole basis for defining the geographic market.[27] As one panelist stated: "if [Elzinga-Hogarty] is the only tool that is being used . . . it blurs everyone's vision as to who really are the competitors and the alternatives that matter."[28] Panelists and commentators identified numerous problems with the application of critical loss analysis, although panelists and commentators agreed that it can be a useful tool.[29]

---

[23] The Elzinga-Hogarty test is named for the two economists who first proposed this particular analysis. *See* Kenneth Elzinga & Thomas Hogarty, *The Problem of Geographic Market Delineation in Antitrust Suits*, 18 ANTITRUST BULL. 45 (1973) [hereinafter Elzinga & Hogarty, *The Problem*]; Kenneth Elzinga & Thomas Hogarty, *The Problem of Geographic Market Delineation Revisited: The Case of Coal*, 23 ANTITRUST BULL. 1 (1978) [hereinafter Elzinga & Hogarty, *The Problem Revisited*].

[24] The term "critical loss analysis" was first used in an article: Barry Harris & Joseph Simons, *Focusing Market Definition: How Much Substitution Is Necessary?* 12 RES. IN L. & ECON. 207 (1989).

[25] *See* FTC v. Tenet Healthcare Corp., 17 F. Supp. 2d 937 (E.D. Mo. 1998), *rev'd* 186 F.3d 1045 (8th Cir. 1999). In this case, the Eighth Circuit relied on both an Elzinga-Hogarty test and a critical loss analysis to conclude that a broad geographic market was appropriate. Similarly, in *United States v. Mercy Health Services*, 902 F. Supp. 968 (N.D. Iowa 1995), *vacated as moot*, 107 F.3d 632 (8th Cir. 1997), the District Court relied on patient migration patterns, regional hospitals' outreach clinics, and the lack of evidence that patients' loyalty to their physicians would prevent them from defeating a price increase to find a broad geographic market. *See also* J. Jacobs 3/28 at 72-74 (noting DOJ lost the *Mercy Health* case on the geographic market definition for all of these reasons, but believes that the government could address successfully some of these issues today); California v. Sutter Health Sys., 84 F. Supp.2d 1057 (N.D. Cal. 2000) (insufficient evidence of a relevant geographic market); FTC v. Freeman Hosp., 911 F. Supp. 1213 (W.D. Mo.), *aff'd*, 69 F.3d 260 (8th Cir. 1995) (holding the Commission had failed to identify a relevant geographic market).

[26] *See* Hammer & Sage, *supra* note 8, at 90; Frech 3/26 at 189-191; Greaney 2/27 at 141-42; Greaney , *supra* note 8.

[27] *See* Werden 3/26 at 248-50 (the data may provide descriptive information, but you cannot draw strong conclusions); Guerin-Calvert 3/26 at 139; Guerin-Calvert Presentation, *supra* note 20, at 17; Frech 3/26 at 190-91 (noting that patient flow data and the Elzinga-Hogarty ratios are useful background, but make no sense when used as a bright line to define the geographic market); Vistnes 3/26 at 251-52; Argue 3/28 at 44 (Elzinga-Hogarty is a static analysis and does not address the dynamic nature of markets).

[28] Guerin-Calvert 3/26 at 139; Guerin-Calvert Presentation, *supra* note 20, at 17.

[29] *See, e.g.*, Harris 3/26 at 171-78, 222-24; Guerin-Calvert 3/26 at 125, 130-31; Werden 3/26 at 201-205, 212-20, 248-50; Frech 3/26 at 189-90; Daniel O'Brien & Abraham Wickelgren, *A Critical Analysis of Critical Loss Analysis*, 71 ANTITRUST L.J. 161, 161-62 (2003); Michael Katz & Carl Shapiro, *Critical Loss: Let's Tell the Whole*

Several panelists offered alternative analytical tools and other types of evidence to use in defining the geographic market for a hospital. Most panelists agreed that no one piece of information is sufficient to define a hospital's geographic market.[30] In essence, panelists agreed the courts should apply the *Merger Guidelines*' hypothetical monopolist test in hospital merger cases, just as they do in merger cases involving other industries and products. The question is how to implement the hypothetical monopolist test, and what analytical frameworks and evidence should be used to do so.

1. Elzinga-Hogarty Test

The Elzinga-Hogarty test was designed to analyze commodity movements, not hospital mergers. It was proposed by two economists in an article critiquing the Agencies' geographic market definitions in two non-hospital merger cases.[31] In one case, the government relied on LIFO ("little in from outside") data to argue that an entire state was the relevant geographic market for beer products. In the second case, the government relied on LOFI ("little out from inside") data to argue that the relevant geographic market for commercial banking was limited to a four-county area.[32] Kenneth Elzinga and Thomas Hogarty argued that a proper geographic market analysis required the use of both LIFO and LOFI statistics, but observed that their analysis was not readily applicable to heterogenous goods or differentiated products.[33] Hospitals

---

Story, 17 ANTITRUST, Spring 2003, at 49-50; James Langenfeld & Wenqing Li, *Critical Loss Analysis in Evaluating Mergers*, 46 ANTITRUST BULL. 299, 299-301 (2001); Kenneth L. Danger & H.E. Frech III, *Critical Thinking About 'Critical Loss' in Antitrust*, 46 ANTITRUST BULL. 339, 340-42 (2001); David Scheffman & Joseph Simons, *The State of Critical Loss Analysis: Let's Make Sure We Understand the Whole Story*, 3 THE ANTITRUST SOURCE, Nov. 2003, *at* http://www.abanet.org/antitrust/source/nov03/ scheffman.pdf.

[30] Vistnes 3/26 at 144, 147-49; Vistnes Presentation, *supra* note 20, at 4-5, 11-18; Guerin-Calvert 3/26 at 131-33; Guerin-Calvert Presentation, *supra* note 20, at 4, 12. *See also* Leibenluft 3/28 at 8-9 ("[On] geographic market, it's sort of a Catch 22. The courts require -- and, I think, rightfully so -- that the analysis be dynamic. What will happen if the hospitals merge? As a result of that, the plaintiff is faced with a difficult task. What they have is traditional hard evidence which relates to, for example, patient flow data, which reflects historical patient patterns, and is historical conduct. But that doesn't reflect what might happen in the future. But when the Government tries to find what may or look to what may suggest what will happen dynamically, then that evidence could be attacked as being speculative or anecdotal."); Feller 9/24 at 66 (discussing geographic markets for physician services and also noting that "zip code analysis, however, only presents a static and limited view of the relevant geographic market").

[31] Elzinga & Hogarty, *The Problem, supra* note 23; *see also* Elzinga & Hogarty, *The Problem Revisited*, *supra* note 23.

[32] Elzinga & Hogarty, *The Problem*, *supra* note 23, at 52-64.

[33] *Id*. at 72-75 & n.75 ("Where the appropriate product market is a set of heterogeneous goods, or where there is product differentiation, or where there are important physical differences among units within the product market, adding together physical units will be difficult if not impossible. In such cases, measuring output in sales instead of physical units might be necessary.").

generally provide heterogenous or differentiated goods and services.[34]

Nonetheless, the "Elzinga-Hogarty test" has been used extensively in hospital merger cases. The movement of a patient who resides within the provisional geographic market to a facility outside of that area for hospital services is considered an importation of hospital services into that provisional geographic market, measured as LIFO. The movement of a patient who resides outside of the provisional geographic market to a facility inside the provisional geographic market for hospital services is considered an exporting of hospital services outside of the provisional geographical market, measured as LOFI.[35] Thus, under the hospital application of the Elzinga-Hogarty test, evidence that few patients leave and few patients enter an area surrounding the merging hospitals is interpreted to support the conclusion that the area constitutes a relevant geographic market.[36]

Conversely, if the patient flow data show large numbers of patients coming into or going out of the area for inpatient hospital care, then the geographic market is hypothesized to be broader than originally thought, and must include hospitals further away from the merging hospitals. A geographic market definition is usually described as "strong" if less than 10 percent of discharged patients from the merging hospitals' area come into or out of the area. If more than 10 percent (but less than 25 percent) of patients migrate in or out of the hospitals' core geographic area for in-patient services, the market definition is considered "weak."[37]

Panelists identified a number of weaknesses with the use of the Elzinga-Hogarty test to define a geographic market for hospital services.[38] One panelist pointed out that the Elzinga-Hogarty test takes a leap in logic from a current level of patient migration to the conclusion that patients would respond to a small price increase by using hospitals outside of the merging hospitals' core geographic area – a leap not justified by either economic analysis or past

---

[34] *See, e.g.*, Zwanziger 3/26 at 92 (The Elzinga-Hogarty approach "is poorly suited to hospital mergers" because it does not recognize the underlying heterogeneity on the supply or demand side of hospital services.); Jack Zwanziger, *Defining Hospital Markets* 2 (3/26) (slides) [hereinafter Zwanziger Presentation], *at* http://www.ftc.gov/ogc/ healthcare hearings/ docs/ zwanziger.pdf.

[35] *See* Gregory Vistnes, *Hospitals, Mergers, and Two-Stage Competition*, 67 ANTITRUST L.J. 671, 689 (2000); Sacher & Silvia, *supra* note 18, at 192-93.

[36] *See* Vistnes, *supra* note 35, at 689; Elzinga & Hogarty, *The Problem*, *supra* note 23, at 72-76; Elzinga & Hogarty, *The Problem Revisited*, *supra* note 23, at 2-3.

[37] *See* Elzinga & Hogarty, *The Problem*, *supra* note 23, at 73-75; Elzinga & Hogarty, *The Problem Revisited*, *supra* note 23, at 2.

If the LIFO and LOFI are both 10 percent or less, then the geographic market satisfies the "strong" Elzinga-Hogarty test. If the LIFO and LOFI are both 25 percent or less then the geographic market satisfies the "weak" Elzinga-Hogarty test. Elzinga & Hogarty, *The Problem Revisited*, *supra* note 23, at 2.

[38] Frech 3/26 at 190-97; Greaney 2/27 at 141-42 (noting that the courts naively interpret Elzinga-Hogarty in health care cases, and that because hospitals offer heterogeneous services and patients have highly diverse preferences, this results in "thoroughly wrong-headed precedents and subdoctrines").

experience.[39] Patients decide whether or not to travel for health care services for a variety of reasons, including perceived and actual variations in quality, insurance coverage, out-of-pocket cost, sophistication of services, and family connections.[40]

Although patient flow data may show that patients go to hospitals beyond the core zip code area, this does not mean that their behavior reflects price sensitivity, or that other consumers would travel if prices increased.[41] Stated differently, patient flow data can show existing hospitalization patterns, but offer no insight into what patients will do in response to a price increase by the merged hospital.

Another panelist described this phenomenon as the "silent majority fallacy."

> The E-H [Elzinga-Hogarty] approach draws a conclusion about the entire market from the behavior of those consumers who express displeasure with their local sellers by traveling elsewhere. This is a valid logical leap when travelers and non-travelers have similar demands and related market experiences. However, if the two groups differ on dimensions other than location, then E-H gives rise to what we call the "silent majority fallacy." That is, if travelers and non-travelers display fundamentally different demand behavior, either because they differ in their taste for travel or their need for local/non-local services, then there is no necessary relationship between the market experiences of these two groups post-merger. If travelers differ significantly from non-travelers, then the presence of a minority of travelers does not imply that local firms lack market power *vis-a-vis* the majority of consumers who are non-travelers.[42]

The silent majority fallacy is a particular problem with hospital merger analysis, because the goods and services are not fungible commodities, but are "highly differentiated by location and other dimensions."[43] Empirical evidence confirms that "the majority of patients are truly

---

[39] Frech 3/26 at 190-95.

[40] *Id*. at 195.

[41] Zwanziger 3/26 at 232-33. *See also id*. at 97-99 (noting that large markets based on patient flow data and Elzinga-Hogarty are incompatible with research knowledge: travel distance is the most important criteria for a patient in deciding which hospital to use).

[42] CORY CAPPS ET AL., THE SILENT MAJORITY FALLACY OF THE ELZINGA-HOGARTY CRITERIA: A CRITIQUE AND NEW APPROACH TO ANALYZING HOSPITAL MERGERS 1 (Nat'l Bureau of Econ. Research, Working Paper No. w8216, 2001) [hereinafter CAPPS ET AL., SILENT MAJORITY]. *See also* Cory Capps et al., *Geographic Market Definition in Hospital Merger Cases* 4 (4/16) [hereinafter Capps et al. (stmt)], *at* http://www.ftc.gov/ogc/healthcare hearings/docs/030410capps2.pdf; Cory Capps, *For-Profit and Non-Profit Pricing: The Empirical Evidence* (4/10) (slides), *at* http://www.ftc.gov/opp/hc/030410corycapps.pdf [hereinafter Capps Presentation]. *See also* Cory Capps et al., *Antitrust Policy and Hospital Mergers: Recommendations for a New Approach*, 47 ANTITRUST BULL. 677, 713-14 (2002) [hereinafter Capps et al., *Antitrust Policy]*.

[43] CAPPS ET AL., SILENT MAJORITY, *supra* note 42, at 1-2.

reluctant to travel and do not view distant hospitals as close substitutes for most services, even though a sizable percentage of their neighbors may travel for care. Those who do travel have distinct reasons for doing so and the fact that they travel would not inhibit merging local hospitals from increasing prices substantially."[44]

One panelist also noted that in some circumstances, the Elzinga-Hogarty test cannot be satisfied. If the initial specification of the geographic market does not meet the required threshold for LIFO and LOFI, expanding the geographic market may not satisfy the required threshold either. The result is that the geographic market expands without limit.[45] This problem alone casts serious doubt on the utility of the Elzinga-Hogarty methodology for hospitals.

This same panelist suggested that the Elzinga-Hogarty test systematically leads to expansive geographic markets when zip codes are selected based on the absolute number of patients that come from a zip code.[46] There is tremendous variability in the number of individuals that live in a particular zip code. A hospital may have a small share of total admissions from a particular zip code, even though it gets a significant number of patient admissions from that zip code – and the Elzinga-Hogarty test, as used in hospital mergers, will include such distant zip codes in the market. According to this panelist, "a zip code that has 20,000 people, that's 40 miles away, might get included if the hospital gets 50 patients from there, whereas ten zip codes that are closer that only have a thousand people each, might send 40 people each, they would get excluded."[47] He suggested that such large and distant zip codes are particularly likely to be cities that have hospitals in them, which skews the results of the analysis from the outset.[48]

2. Critical Loss Analysis

Critical loss analysis has the potential to provide a useful way to implement the hypothetical monopolist test, but it must be applied with great care.[49] Problems with its application have led some commentators to question the value of critical loss analysis as an

---

[44] *Id*.

[45] Frech 3/26 at 195 ("[A]s you expand the area to get to a high enough percentage to call it a service area, you keep picking up more hospitals, and that keeps making it more difficult" to reach a cut-off.). Professor Frech noted that even at the 75 percent level, the defendant's expert could not find a cut-off for the Poplar Bluff geographic market area in the *Tenet* case. *Id*. at 195.

[46] Frech 3/26 at 192 ("[R]anking zip codes by the number of patients usually gives the largest market areas.").

[47] *Id*. at 192-93. *See also* H.E. Frech, III et al., *Elzinga-Hogarty Tests and Alternative Approaches for Market Share Calculations in Hospital Markets*, 71 ANTITRUST L.J. 921, 928-29, 941-47 (2004).

[48] Frech 3/26 at 192-93.

[49] *e.g.*, Scheffman & Simons, *supra* note 27, 61 at 2-3; Harris 3/26 at 170-75; Werden 3/26 at 201-04.

antitrust tool.[50]

Conventional critical loss analysis posits a particular price increase and asks what proportion of the hypothetical monopolist's sales would have to be lost to yield a net decrease in the hypothetical monopolist's profits.[51] When critical loss analysis is used to delineate a relevant market, the first step is to calculate the percentage loss in sales that would make a given price increase unprofitable for a hypothetical monopolist over a candidate market. This calculation depends on the price increase posited and on the contribution margin (*i.e.*, price minus marginal cost, all divided by price) on the sales that would be lost.[52]

The second step is to estimate the likely actual loss in sales that would result from the hypothesized price increase, *e.g.*, what percentage of patients likely would stop patronizing the hospitals in the candidate market in response to the price increase.[53] The estimated actual loss is then compared to the calculated critical loss. If the estimated actual loss exceeds the critical loss, it is inferred that the price increase would be unprofitable and the candidate market is too small to be a market.[54]

One panelist described misuses of the critical loss technique that practitioners should avoid.[55] Notably, typical applications posit small (*e.g.*, five percent) price increases. Yet, the *Merger Guidelines'* methodology for delineation of relevant markets asks whether the profit-maximizing price increase would be at least a small but significant amount (*e.g.*, five percent). Even though a monopolist may find a five percent price increase unprofitable, it may find a larger price increase profitable.[56] This panelist presented an example based on the stylized facts of several hospital merger cases in which a five percent price increase would be unprofitable, but any price increase between 31 percent and 319 percent would be profitable, and the hypothetical

---

[50] *See supra* note 29.

[51] One also can ask how much of a reduction in its sales the hypothetical monopolist would be willing to tolerate to sustain a given price increase. Only asking this alternative calculation actually implements the Horizontal Merger Guidelines' hypothetical monopolist test, but the analysis described in the text yields roughly the same result under plausible conditions. Werden 3/26 at 202-04; Werden Presentation, *supra* note 20, at 4-5.

[52] Harris 3/26 at 170-75. The formula for the critical loss for an x% price increase is $x/(x + m)$, where m is the margin, expressed as a percentage price. For example, if the margin is 60 percent, the critical loss for a 5 percent price increase is $5/(5 + 60) = .077$, or 7.7 percent.

[53] *Id*. at 174-75.

[54] Scheffman & Simons, *supra* note 29, at 2-3 (outlining a three-step process for conducting a critical loss analysis); *see also* Katz & Shapiro, *supra* note 29, at 49-50; O'Brien & Wickelgren, *supra* note 29, at 161.

[55] Werden 3/26 at 204-05; Werden Presentation, *supra* note 20, at 8.

[56] Werden 3/26 at 204-05; Werden Presentation, *supra* note 20, at 8, 11, 14.

monopolist would maximize its profits by increasing price 175 percent.[57] Thus, the candidate market was a market under the *Merger Guidelines'* hypothetical monopolist test, even though a five percent price increase was unprofitable.

This panelist discussed other problems that occur in some implementations of critical loss analysis. The standard formula presumes constant marginal cost and no avoidable fixed costs, but actual cost functions may differ significantly from this assumption. Also, the standard formula implicitly assumes proportionate increases in all prices, but the profit maximizing strategy for hospitals may involve highly disproportionate price increases.[58] This panelist also explained that critical loss calculations must focus on the margins for the patients that likely would be lost in the event of a price increase.[59]

Much of the potential for abuse in critical loss analysis involves the second step – estimation of the actual loss. Some practitioners have relied in inappropriate ways on consumer surveys or patient flow data to estimate the actual losses in sales that would result from a price increase. For example, some practitioners use patient flow data to identify zip codes that are "contestable."

These practitioners then argue that the share of patients in these zip codes that would stop patronizing certain hospitals in a candidate geographic market in response to a given price increase would be greater than the critical loss, and that the geographic area must therefore be expanded in order to constitute a relevant geographic market.[60] Data on existing travel patterns for residents in a zip code, however, say nothing about why patients select specific hospitals or how a change in relative prices would affect patient migration.[61] One cannot infer that just because some patients in a zip code currently choose more distant hospitals, others also would choose such hospitals if the prices of the merging hospitals increased.[62]

---

[57] Werden 3/26 at 209-17; Werden Presentation, *supra* note 20, at 15-19.

[58] Werden 3/26 at 204-05; Werden Presentation, *supra* note 20, at 14.

[59] Werden 3/26 at 219-20 (noting that it is important to properly calculate the margin, and that in hospital mergers it is possible that not all patients contribute the same margin – depending on which patients are likely to leave if faced with a price increase, the margin, and therefore, the critical loss, may differ). For similar critiques, *see* Danger & Frech, *supra* note 29; Langenfeld & Li, *supra* note 29.

[60] Alternatively, these zip codes are identified as "at risk" or "overlapping." Harris 3/26 at 177-78; Frech 3/26 at 189-190.

[61] *See* CAPPS ET AL., SILENT MAJORITY, *supra* note 42; Capps et al., *Antitrust Policy*, *supra* note 42, at 679-82, 690-92, 694-704.

[62] Frech 3/26 at 189-90 (noting that the predicted actual loss is an important part of how critical loss analysis is implemented, and as typically implemented, critical loss analysis leads to implausibly large geographic areas).

Recent commentary, some of it published after the Hearings, has stressed a link between the first and second steps of critical loss analysis.[63] As a simple matter of arithmetic, the higher the contribution margin, the smaller the critical loss will be for a given price increase. The higher the margin, the more it costs the hypothetical monopolist to lose a sale, and so the smaller the sales loss required to offset the profit gain from making the remaining sales at a higher price.[64]

Yet if firms are maximizing profits before the merger, high margins indicate that those firms face low price elasticities of demand.[65] Otherwise, these firms could earn greater total profits by *reducing* prices and expanding sales. Moreover, a hypothetical monopolist over any candidate market must face a lower elasticity of demand than the individual firms in that candidate market, so high margins must imply a very low demand elasticity for the candidate market.

Hospitals' experts commonly argue that merging hospitals' margins are high, which implies that the critical losses are low. They argue that post-merger price increases would be unprofitable because of the high per-unit foregone profits on lost sales. In essence, they argue that where the critical loss is low, the actual loss will exceed the critical loss. On this basis, they argue that relevant geographic markets for hospital mergers are broad.[66]

Yet, as discussed above, high margins also imply low demand elasticities. Low demand elasticities indicate that the merged firm's actual losses of sales would be low. Because the actual losses may be less than the critical losses when margins are high, the relevant geographic

---

[63] Danger & Frech, *supra* note 29 at 349-51; Katz & Shapiro, *supra* note 29, at 49-50, 52-53; Langenfeld & Li, *supra* note 29, at 302-03, 307-08; O'Brien & Wickelgren, *supra* note 29, at 161-63.

[64] *See* Katz & Shapiro, *supra* note 29, at 50; O'Brien & Wickelgren, *supra* note 29, at 161-62; Scheffman & Simons, *supra* note 29, at 4.

[65] *See* Katz & Shapiro, *supra* note 29, at 50-51; O'Brien & Wickelgren, *supra* note 29, at 162; Danger & Frech, *supra* note 29, at 349-51; Langenfeld & Li, *supra* note 29, at 308-09, 323; Michael Katz & Carl Shapiro, *Further Thoughts on Critical Loss*, 3 THE ANTITRUST SOURCE, Mar. 2004, *at* http://www.abanet.org/antitrust/source/march04 /katzshapiro.pdf; Daniel O'Brien & Abraham Wickelgren, *The State of Critical Loss Analysis: Reply to Scheffman and Simons*, 3 THE ANTITRUST SOURCE, Mar. 2004, *at* http://www.abanet.org/ antitrust/source/march04/obrienwickel.pdf. *But see* Scheffman & Simons, *supra* note 29, at 5 (disagreeing with critiques that attempt "to infer, with greater specificity, a value of AL [actual loss] from incremental margins and (too simple an) economic theory").

[66] One panelist defended critical loss at the Hearings as an appropriate mechanism for analyzing proposed hospital geographic markets. Harris 3/26 at 167, 173-74. This panelist recommended that the parties and court closely examine documents, data, and testimony to determine the elasticity of demand and how many patients are likely to leave if faced with an anticompetitive price increase. Harris 3/26 at 222-24. He did not, however, address the argument that the premerger margin itself contains substantial information about the likely switching behavior of consumers.

market may in fact be narrow.[67]

Other commentators also have described ways in which critical loss analysis has been carried out incorrectly, both for delineation of markets and for competitive effects analysis.[68] One article cites four key problems in how courts have applied critical loss analysis in recent hospital mergers.[69]

First, courts have failed to consider whether a price increase greater than five percent would be profitable. Second, courts have failed to consider the fact that high margins often mean a firm faces inelastic demand and, therefore, actual losses would be low. Third, courts did not consider that, if prices increased, some consumers might be diverted to one of the merged firms. Finally, courts have assumed, contrary to economic theory, that firms in the area surrounding the merged firm would keep the same prices even though the merged firm raised its prices.[70] Thus, critical loss analysis may be useful in defining geographic markets and for competitive effects analysis only if it is applied appropriately.

3. Alternative Analytical Techniques

One panelist proposed an alternative analytical framework built on the observation that

---

[67] Katz & Shapiro advocate focusing on what they term the "aggregate diversion ratio" to indicate whether the elasticity of demand for the candidate market is sufficiently lower than the firm-level demand elasticities so that the candidate market is, in fact, a market. Suppose there are three products in the candidate market, A, B, and C, and the price of A is increased by five percent. The aggregate diversion ratio is the percentage of sales lost by A that is recaptured by B and C. Katz and Shapiro argue that the actual loss is less than the critical loss if and only if the aggregate diversion ratio exceeds the critical loss. Katz & Shapiro, *supra* note 29, at 53-54. *See also* O'Brien & Wickelgren, *supra* note 29, at 184 ("We have shown that the inference typically drawn from critical loss analysis – that high margins make a merger less likely to be anticompetitive – is often inconsistent with economic theory . . . . In our opinion, critical loss analysis has led to enormous confusion about the economic factors that govern firms' pricing incentives. The technique has been misused so frequently that arguments that are inconsistent with basic economic theory have almost gained a measure of legitimacy in antitrust cases.").

[68] Frech 3/26 at 189, *citing* to Danger & Frech, *supra* note 29. *See also* Langenfeld & Li, *supra* note 29, at 301, 313, 323-333; O'Brien & Wickelgren, *supra* note 29, at 162, 168-73, 177-84; Katz & Shapiro, *supra* note 29, at 50-51, 54-55.

[69] Langenfeld & Li, *supra* note 29, at 323-24, 332-33. Many of these same problems have been identified by other researchers. *See, e.g.*, Danger & Frech, *supra* note 29, at 341-42; O'Brien & Wickelgren, *supra* note 29, at 162, 184; Katz & Shapiro, *supra* note 29, at 52-55.

[70] Langenfeld & Li, *supra* note 29, at 332-333. The formula for critical loss is $x/(x + m)$, where x is the percentage price change of interest (*e.g.*, 5%) and m is the premerger price cost margin ((p-c)/p), expressed as a percentage. In equilibrium, $m = 1/\epsilon$, where ϵ is the elasticity of demand. If ϵ is small and premerger margins are therefore high, it will also be true (by definition of elasticity) that a given price increase will induce only small changes in quantity. *See* O'Brien & Wickelgren, *supra* note 29, at 167-68; Katz & Shapiro, *supra* note 29, at 50-53; Danger & Frech, *supra* note 29, at 342-50; Langenfeld & Li, *supra* note 29, at 303-05, 334-337; *But see* Scheffman & Simons, *supra* note 29, at 5-8 (arguing that critiques of critical loss analysis that use the formula ($m = 1/\epsilon$), or the Lerner Equation, use "the simplest economic model of pricing" to infer that actual loss would be equal or close to critical loss in equilibrium and thereby inappropriately shift the burden of proof to defendants).

hospitals compete in two stages.[71] According to this panelist, the Agencies typically focus on first-stage competition, in which hospitals compete to be included in the networks of health plans. At this point, health plans are the buyers, and prices may be constrained if a health plan can credibly threaten to, or actually, exclude the merging hospitals from its provider network and divert patients to alternative hospitals. The focus for defining the geographic market for this first stage of competition is on hospital locations, not patient locations.[72] Once a hospital is in the plan's network, or in some cases even if it is not, the hospitals then compete at the second stage – for the individual patient.

This panelist suggested that defendants typically focus on second-stage competition for patients and argue for broader geographic markets based on patient flow data.[73] This level of competition differs significantly from the first stage.[74] A two-stage analysis may result in different geographic markets and different competitive effects for each stage, because the two stages involve different customers, different means of competition, and different evidence.[75] If anticompetitive effects are demonstrated at either stage, the merger should be enjoined, according to this panelist.[76]

Another panelist disagreed with the two-stage analysis, noting that it might be worth looking at "as a stylized construct," but that "the appropriate model in which to analyze the factors that drive the pricing decisions and the profitability decisions of the hospitals are such that one cannot separate out the two stages."[77] She suggested that the distinction is even less relevant now, because most plans have inclusive provider networks. In these circumstances,

---

[71] Vistnes 3/26 at 145-146; Vistnes Presentation, *supra* note 20, at 2, 4; Vistnes, *supra* note 35, at 671-692.

[72] Vistnes 3/26 at 148; Vistnes Presentation, *supra* note 20, at 5; Vistnes, *supra* note 35, at 674-81, 692. *See also* Town 4/9 at 60-67 (discussing simulation study that showed significant post-merger price increases to HMOs even though an Elzinga-Hogarty analysis suggested little, if any competitive harm; this suggests that it is important to focus on the price negotiations between hospitals and payors and the ability of a payor to exclude a particular hospital if they cannot reach a price agreement).

[73] Vistnes 3/26 at 157-60; Vistnes Presentation, *supra* note 20, at 11-14; Vistnes, *supra* note 35, 671-74, 681-84, 688-92. *See also* Frech 3/26 at 196-98 (agreeing that with managed care, there are now two stages of competition, and that patient flow data is static and only reflects competition at the consumer or second-stage level, but not at the payor or first-stage level, because changes in payors' hospital networks move too slowly to be captured in the patient flow data).

[74] Vistnes 3/26 at 160; Vistnes Presentation, *supra* note 20, at 13-14; Vistnes, *supra* note 35, at 681-84.

[75] Vistnes 3/26 at 146-47; Vistnes Presentation, *supra* note 20, at 13-14; Vistnes, *supra* note 35, at 672-74, 688.

[76] Vistnes 3/26 at 160; Vistnes Presentation, *supra* note 20, at 14; Vistnes, *supra* note 35, at 672-73.

[77] Guerin-Calvert 3/26 at 230.

network inclusion provides no assurance that patients will seek care at a particular hospital.[78]

Another panelist submitted a joint statement proposing a different analytical framework for analyzing geographic markets in hospitals. The statement asserts that because potential patients select managed care organizations (*e.g.*, health insurers) prior to knowing what their medical needs will be, the subsequent *ex-ante* pricing makes the connection between patient flows and pricing power tenuous.[79] For example, the statement suggests that "100% of patients place a high value on having access to a local hospital," but if they are part of the 20 percent of the group that develop a serious medical condition, these same patients may be willing to travel any distance to go to the best hospital for their condition.[80]

As an alternative, the statement proposes a formal demand analysis model that would require data on patient and hospital characteristics in addition to the patient origin and destination data traditionally used. Although this model is more complex than patient flow analysis, the statement contends it provides "a measure of market power that, unlike patient flows, is theoretically valid for differentiated goods markets and is directly related to the prices that hospitals are able to charge."[81]

B. Other Evidentiary Sources

Panelists suggested numerous additional sources of evidence that should be used to establish the geographic market for hospital services. The recommended sources include types of evidence typically assessed in non-hospital merger cases: strategic planning documents and testimony from the merging parties and their competitors, and documents and testimony from major purchasers of services from the merging parties – here, third-party payors.

Panelists also suggested the use of evidence that casts direct light on the distances patients are willing to travel and the reasons they are willing to do so, and evidence that demonstrates the role, if any, physicians can play in defeating a hospital's post-merger, anticompetitive price increases. Each of these categories of evidence are considered below.

---

[78] *Id*. at 230-31. *But see* Vistnes 3/26 at 243 (arguing that even if all hospitals are in a plan's network today, as long as the plan can credibly threaten to exclude the hospital, that possibility of exclusion is a constraint on pricing).

[79] Capps et al. (stmt), *supra* note 42, at 5.

[80] *Id*. at 5-6.

[81] *Id*. at 6. The authors refer readers to another paper (Cory Capps et al., *Competition and Market Power in Option Demand Markets* (April 2003) (unpublished manuscript)), in which they "provide a step by step derivation and empirical implementation of a market power measure that correctly incorporates the *ex-ante* nature of hospital pricing." *Id*. at 6-7. These authors also published another article outlining option demand analysis, as well as two other analyses. The authors suggest that the other two analytical techniques are not as accurate as the formal option demand analysis, but they are useful in defining hospital geographic markets. *See* Capps et al., *Antitrust Policy*, *supra* note 42, at 681.

1. Hospital Strategic Planning Documents

The Agencies typically examine strategic planning documents from the merging parties and their competitors to assess relevant market and other key issues in merger analysis. Panelists suggested using strategic planning documents from the hospitals to help establish the proper geographic market.[82] Such documents may specify the geographic regions in which a hospital is marketing its services and the hospitals it sees as its primary competition.[83] In addition, a hospital's strategic planning documents frequently disclose the hospital management's assessment of the extent to which the proposed merger will increase the hospital's negotiating power and its ability to raise prices. Hospital strategic planning documents can illuminate hospital competition for both inclusion in payor networks and for individual patients.

2. Payor Testimony

For non-hospital mergers, the Agencies regularly obtain the views of the merging firms' major customers to assess issues such as relevant market definition and competitive effects. These market participants typically have the most price negotiation experience with the merging firms, as well as the most to lose from price increases (or quality or other degradations) if the proposed merger were to create market power. On the other hand, major customers also have much to gain from reduced prices if the proposed merger would likely create efficiencies that would be passed on to customers.

Courts, however, have been skeptical about testimony from third-party payors in hospital merger cases, even though these payors routinely negotiate with hospitals about price and other aspects of hospital care. In *Tenet,* for example, the Eighth Circuit questioned the district court's reliance on payor testimony that they "would unhesitatingly accept a price increase rather than steer their subscribers to hospitals" outside of the core geographic area.[84] The Eighth Circuit believed that, although the testimony might have been truthful, the payors "spoke to current competitor perceptions and consumer habits and failed to show where consumers could practicably go for inpatient hospital services."[85]

By contrast, panelists stated that payors can offer useful testimony on at least two distinct

---

[82] Guerin-Calvert 3/26 at 141-43, 226, 237-39; Harris 3/26 at 223.

[83] *See, e.g.*, Guerin-Calvert 3/26 at 141 (stating that documents show who the hospitals see as their competitors and strategic plans of hospitals competing with merging hospitals often show strategies for taking patients from another hospital); Guerin-Calvert Presentation, *supra* note 20, at 12.

[84] FTC v. Tenet Health Care Corp., 186 F.3d 1045, 1054 & n.14 (8th Cir. 1999).

[85] *Tenet Health Care*, 186 F.3d at 1054 & n.14. *See also* Greaney 2/27 at 142 (finding it inexplicable that two circuits have "adopted an evidentiary rule of thumb that discounts the credibility of the testimony of third party payers on facts that are really central to their business … when [the testimony is] unimpeached, not impeached by a showing of bias or other defects").

issues.[86] Payors have considerable insight into hospital geographic markets, because they must factor such matters into their decision whether to contract with a hospital in the first instance. Payors must strive to include a sufficient number of hospitals in each geographic market, because if they fail to do so, the plan is less appealing to purchasers, including benefit managers that must make recommendations and decisions for employers and other group purchasers.[87] Accordingly, payors can offer useful testimony on the extent to which particular hospitals engage in price and non-price competition with one another.

Second, panelists suggested that payor testimony also would be helpful in determining whether payors can steer patients to a lower-cost hospital if prices increase post-merger.[88] Several panelists noted that payors used to create marketable plans with limited provider networks and thus could exclude a hospital if its prices were not acceptable to the plan.[89] Today, many consumers demand choice and open provider networks.[90] Therefore, payors frequently rely on mechanisms other than excluding hospitals to divert marginal consumers to lower-cost alternatives.[91] For example, payors are currently experimenting with tiered networks that provide differing levels of coverage and co-payments based on the facility at which care is

---

[86] *See, e.g.*, Leibenluft 3/28 at 15-16; Vistnes 3/26 at 147-57.

[87] *See, e.g.*, Vistnes 3/26 at 148-50; Eisenstadt 3/28 at 60-61.

[88] *See, e.g.*, Guerin-Calvert 3/26 at 140-43 (suggesting looking not only at what payors say about which hospitals are critical to their networks, but at what payors have done in the past to respond to different market behaviors, such as price increases or quality decreases); Guerin-Calvert Presentation, *supra* note 20, at 13, 16, 18; *see also* Singer 3/28 at 37-38; Toby Singer, *Issues in Litigating Hospital Mergers* 2-5 (3/28) ("In particular, the courts have not been willing to believe the testimony of health plans and others when it is contradicted by other evidence, such as statistical evidence on market definition," *citing* to *California v. Sutter Health System*, 84 F. Supp. 2d 1057 (N.D. Cal.), *aff'd mem.*, 2000-1 Trade Cas. (CCH) ¶87,665 (9th Cir. 2000), *revised*, 130 F. Supp. 2d 1109 (N.D. Cal. 2001)); *United States v. Long Island Jewish Medical Center*, 983 F. Supp. 121 (E.D.N.Y. 1997); *Adventist Health System/Est*, 114 F.T.C. 458 (1991), *at* http://www.ftc.gov/ogc/healthcarehearings/docs/030328singertoby.pdf; Argue 3/28 at 49-51.

To be sure, a court will wish to assess the consistency of a witness's testimony with its documents and evidence of its previous actions. With respect to payor testimony, however, some judicial skepticism appears to be based, at least in part, on patient flow data. For the reasons discussed *supra,* patient flow data does not provide reliable information about what payors could do if faced with hospital price increases.

[89] Guerin-Calvert 3/26 at 138-39.

[90] *Id*. at 138-39. Some believe that the recent increases in insurance premiums are, at least in part, due to these demands for more choice and broader provider networks. *See supra* Chapter 1 and *infra* Chapter 5.

[91] Guerin-Calvert 3/26 at 134, 141 (referring to cases where payors were able to move marginal patients); Vistnes 3/26 at 152-56 (listing possible strategies payors could use to divert patients: dropping a hospital from the network; adding hospitals to the network to "dilute" the patient base; creating incentives for patients to switch hospitals; creating incentives for physicians to admit elsewhere; and changing the physician panel); Vistnes Presentation, *supra* note 20, at 8; Harris 3/26 at 180 (stating payors use various mechanisms to shift patient choices, including different copays and deductibles, tiered plans, and cafeteria plans).

received.[92] Testimony regarding the feasibility and performance of such strategies would be helpful in determining the alternatives available to payors in the event of post-merger price increases.[93]

Panelists expressed different views on whether and to what extent payors can "steer" patients and the types of evidence that can help answer this question. One panelist noted that if payors actually can steer patients to (or away) from particular institutions, the distances traveled to hospitals should have grown in parallel with the rise of managed care.[94] In fact, the panelist noted, the distances patients travel to hospitals have not changed very much since the mid-1980s, and there is little distinction between the distances traveled for HMO versus non-HMO patients.[95] Based on this evidence, the panelist maintained that courts should not assume that payors can effectively steer patients in response to price increases.[96]

Another panelist suggested that patient flow data may help show whether and, if so, how payors can steer patients.[97] This panelist asserted that payors have had enough success in moving marginal consumers to lower-cost hospitals that, in most cases, they can discipline hospital price increases.[98] She also concluded that in many cases, even if payors testify accurately that they must have the merging parties in their networks, that is not necessarily sufficient to give the hospitals unilateral power over price.[99]

Other panelists were more skeptical about these claims. One panelist stated that,

---

[92] *See supra* Chapter 3.

[93] *See, e.g.*, Guerin-Calvert 3/26 at 140-43; Frech 3/26 at 186-88.

[94] Frech 3/26 at 186-88.

[95] *Id*. *See also* H. E. Frech III & Lee Rivers Mobley, *Managed Care, Distance Traveled and Hospital Market Definition*, 37 INQUIRY 369-384 (2000).

[96] Frech 3/26 at 186-88; Zwanziger 3/26 at 98-99 (describing research that suggests that travel distance is the most important criteria for a patient in deciding which hospital to use, and in California, where managed care penetration went from 20 percent to 90 percent over a specific period of time, the average travel distance changed very little over that same period).

[97] Guerin-Calvert 3/26 at 134, 137, 141. *But see* Frech 3/26 at 197 (noting that turn-over among the hospitals included in a plan is sufficiently infrequent that patient flow data will often not capture the dynamics of first-stage competition).

[98] Guerin-Calvert 3/26 at 140-41, 143; *see also* Guerin-Calvert 3/26 at 252 (describing documents in some markets that have included letters from plans to physicians to use one hospital more than another, and patient flow data subsequently showed the shift of enrollees from one hospital to another).

[99] *See* Guerin-Calvert 3/26 at 141-43 (noting that it is rare to find a compelling coordinated-effects story in hospital markets and that the Chattanooga case is the one exception where the court accepted a coordinated effects theory of harm, referring to the Seventh Circuit opinion in *Hospital Corp. of America v. FTC*, 807 F.2d 1381 (7th Cir. 1986)); Guerin-Calvert Presentation, *supra* note 20, at 18.

although in theory payors have mechanisms they could use to divert patients to other hospitals, in practice these tactics are often costly and counter-productive to a health plan's marketability and profitability.[100] This panelist argued that it is difficult (if not impossible) to target incentives to the insured consumers who are most likely to be affected. A payor must consider the cost of providing a lower copayment to all patients, not just the marginal patients the payor is trying to steer.[101] Moreover, other hospitals may have higher prices than the merged hospitals, even assuming price increases as a result of the merger.[102]

3. Patients' Willingness to Travel – How Far and Why?

Several panelists suggested that courts should give more weight to empirical studies of patients' willingness to travel to receive health care. Studies indicate that most patients prefer to be hospitalized close to their homes.[103] Some patients appear willing to travel long distances for very serious or complicated procedures, but many patients prefer to receive such care in their local hospital, even if their local hospital has higher mortality rates and less experience with such procedures.[104] Some patients are willing to receive care in a distant city because they work or have family in that city, or because of the hospital's religious affiliation.[105]

Several panelists noted that such migration patterns are unlikely to be price sensitive, yet the application of the Elzinga-Hogarty test and critical loss analysis would result in a large geographic market in such circumstances, if enough patients traveled for these non-price reasons.[106]

4. Physicians' Willingness and Ability to Steer Patients to Less Expensive Alternatives

---

[100] Vistnes 3/26 at 150-60.

[101] *Id*. at 154-56.

[102] Vistnes 3/26 at 156; Vistnes Presentation, *supra* note 20, at 9. *But see* FTC v. Tenet Healthcare Corp., 186 F.3d 1045, 1054 & n.14 (8th Cir. 1999), *rev'g* finding for plaintiff in FTC v. Tenet Health Care Corp., 17 F.Supp. 2d 937 (E.D. Mo. 1998) (finding that district court erred in rejecting more distant hospitals that were more costly because in doing so it "underestimated the impact of nonprice competitive factors, such as quality").

[103] *See, e.g.*, Zwanziger 3/26 at 97-99; Zwanziger Presentation, *supra* note 34, at 10; Frech 3/26 at 186-88. *See generally* Robert Town & Gregory Vistnes, *Hospital Competition in HMO Networks*, 20 J. HEALTH ECON. 733, 746-48 (2001).

[104] *See, e.g.*, Zwanziger Presentation, *supra* note 34, at 9-10; Zwanziger 3/26 at 97-99. *See generally* Town & Vistnes, *supra* note 103, at 746-48.

[105] Zwanziger 3/26 at 98; *see also* Frech 3/26 at 194 ("[C]ustomers migrate from small towns to larger cities for idiosyncratic reasons … [including h]igher quality, more sophisticated services, [and] family connections.").

[106] *See, e.g.*, CAPPS ET AL., SILENT MAJORITY, *supra* note 42; Capps et al. (stmt), *supra* note 42, at 1-6, 9; Zwanziger 3/26 at 97-99; Frech 3/26 at 194.

Several hearing participants suggested that payors may be able to provide financial incentives to physicians to steer patients to less expensive hospitals.[107] Some of the proposals included requiring physicians to agree to a financial risk-sharing contract, threatening physicians with exclusion from a plan's network, imposing financial penalties on physicians who admit patients to the higher-priced hospitals, and providing bonuses to physicians who admit to lower-priced hospitals.[108]

Even though such incentives are theoretically possible, it does not follow that payors would find them useful or desirable.[109] Indeed, such incentives could make a plan less marketable to employers and consumers who value open networks and unrestricted access to health care. Such incentives also could interfere with continuity of care, particularly if patients must use a different physician when they are diverted to a different hospital.[110] These incentives also are unlikely to be effective if they require patients to travel long distances and physicians to travel those same distances to provide care.

C. Summary

The definition of a relevant geographic market has proven to be one of the most daunting components of a hospital merger case. Nonetheless, some guiding principles are clear. The hypothetical monopolist test of the *Merger Guidelines* should be used to define geographic markets in hospital merger cases. The types of evidence used in *all* merger cases – such as strategic planning documents of the merging parties and customer testimony and documents – should also be used to delineate relevant geographic markets in hospital merger cases. The Agencies believe that courts have given insufficient weight to payor testimony and documents in particular.

Empirical evidence is desirable on certain issues, such as the extent of patients' willingness to travel to distant hospitals in response to a small, but significant and non-transitory increase in price. Patient willingness to travel for non-price related reasons does not provide a sufficient basis to infer patient willingness to travel to distant hospitals in response to price increases.

The Agencies encourage further research to determine the circumstances in which patients will travel to distant hospitals in response to price increases. Empirical evidence also is

---

[107] Guerin-Calvert 3/26 at 252; Vistnes 3/26 at 153.

[108] *See, e.g.*, Vistnes 3/26 at 153-57.

[109] *See, e.g.*, *id*.

[110] *Id*. at 153-54, 156-58 (suggesting looking at whether there are overlapping hospitals where physicians have or could likely have admitting privileges or determining how far physicians are willing to travel to perform daily rounds at the hospitals in which they have patients admitted).

desirable on the extent to which physicians can and will steer patients to lower-cost hospitals in response to price increases. To be persuasive, direct evidence should show that such steering by physicians is feasible, cost-effective, and likely.[111] The Agencies also encourage additional research to validate or refute the alternative analytical techniques discussed *supra.*

To date, and for the reasons discussed *supra,* the Agencies' experience and research indicate that the Elzinga-Hogarty test is not valid or reliable in defining geographic markets in hospital merger cases. In addition, if critical loss analysis is used, it must be used with great care to avoid the problems of application discussed in this section. The use of the Elzinga-Hogarty test and the misapplication of critical loss analysis has led some courts to find hospital geographic markets that are improbably large.

III. PRODUCT MARKET DEFINITION

The *Merger Guidelines* provide the framework for defining the relevant product market for hospital services. The product market has typically been defined as a broad group of medical and surgical diagnostic and treatment services for acute medical conditions where the patient must remain in a health care facility for at least 24 hours for recovery or observation.[112]

Over the past twenty years, many hospital merger cases have considered and rejected outpatient services as part of the relevant product market for hospitals. For example, in *In re Hospital Corp. of America*, 106 F.T.C. 361 (1985), the Commission noted that, although outpatient care for certain services might be a separate relevant market or markets, the evidence demonstrated "that the core and vast majority of an acute care hospital's business is acute inpatient care" and non-hospital outpatient providers could not defeat post-merger anticompetitive behavior affecting hospital inpatients.[113]

The Seventh Circuit agreed, observing that "although hospitals increasingly are providing services on an out-patient basis … most hospital services cannot be provided by nonhospital providers; as to these, hospitals have no competition from other providers of medical

---

[111] Some steering mechanisms could implicate federal and/or state anti-kickback and physician self-referral laws. *See supra* Chapter 1.

[112] In *American Medical International*, Inc. and *Hospital Corp. of America*, the FTC defined the relevant product market as a group of general acute care hospital services. Am. Med. Int'l, 104 F.T.C. 1, 107 (1984); *In re* Hosp. Corp. Am., 106 F.T.C. 361 (1985), *aff'd*, 807 F.2d 1381 (7th Cir. 1986).

[113] *Hosp. Corp. Am.*, 106 F.T.C. at 466. In that case, the Commission noted that although "the types of surgical procedures which can be handled on an outpatient basis by surgicenters are increasing, this suggests only that the cluster of inpatient services offered by acute care hospitals is changing and does not indicate that hospitals are becoming head-to-head competitors with such outpatient providers." *Id.*

services."[114] Similarly, in *American Medical International*, 104 F.T.C. 1 (1984), the Commission excluded outpatient services from the product market.[115] The Eleventh Circuit also accepted inpatient acute-care services as the relevant product market in *University Health.*[116] Only one court has included outpatient providers within the product market for inpatient services.[117]

Panelists agreed that providers of outpatient services, such as physicians' offices, urgent care centers, and ambulatory surgery centers, should generally not be included in the product market definition for hospital services.[118] Panelists indicated that from the perspective of payors and patients, inpatient services are complementary and bundled.[119] Even if hospital prices are increased, patients and payors cannot separate nursing care, diagnostic tests, and room and board from the other treatments provided as part of a hospital stay and out-source them.[120] Similarly, demand-side substitution is improbable; a cancer or heart attack patient is not going to substitute obstetrical care if prices for cancer care or heart attacks increase. Because outpatient treatment is generally not a substitute for inpatient care, there was agreement among the panelists that outpatient providers are (and were) correctly excluded from the product market.[121]

---

[114] *Hosp. Corp. Am.*, 807 F.2d at 1388. Similarly, in *United States v. Rockford Memorial Corp.*, 898 F.2d 1278, 1284 (7th Cir. 1990), the Seventh Circuit again affirmed the product market definition as the "provision of inpatient services by acute-care hospitals," noting that other providers cannot compete for many acute-care hospital services. The court further explained that, although patients can choose in-patient hospital care or outpatient providers for some services, those services that can be provided on an outpatient basis are not a check on acute-care in-patient services, because the prices of the two are not linked.

[115] *See Am. Med. Int'l*, 104 F.T.C. at 107.

[116] FTC v. Univ. Health, Inc., 938 F.2d 1206, 1210-11, 1219 (11th Cir. 1991).

[117] United States v. Carilion Health Sys., 707 F. Supp. 840 (W.D. Va.), *aff'd*, 892 F.2d 1042 (4th Cir. 1989) (unpublished opinion).

[118] *See, e.g.*, Sacher 3/26 at 66-70; Zwanziger 3/26 at 95-96, 104-106.

[119] Sacher 3/26 at 69-70; Seth Sacher, *Issues in Defining the Product Market for Hospital Services* 5 (3/26) (slides) [hereinafter Sacher Presentation], *at* http://www.ftc.gov/opp/hc/030326sethsacher.pdf; Sacher & Silvia, *supra* note 18, at 183-85. *See also* Zwanziger 3/26 at 92-98 (discussing heterogeneity on both the supply- and demand-side and suggesting that markets should be defined more narrowly to reflect the different treatments provided and requested); Zwanziger Presentation, *supra* note 34, at 2.

See Am. Med. Int'l, 104 F.T.C. at 107 ("Although each individual service that comprises the cluster of general acute care hospital services may well have outpatient substitutes, the benefit that accrues to patient and physician is derived from their complementarity. There is no readily available substitute supplier of the benefit that this complementarity confers on patient and physician. This is consistent with record evidence that shows that those in the market only recognized other hospitals, not suppliers of individual hospital services, as their competitors.").

[120] Sacher 3/26 at 69-70.

[121] Zwanziger 3/26 at 95-96; Zwanziger Presentation, *supra* note 34, at 6; *see, e.g.*, *Univ. Health*, 938 F.2d at 1210-11; United States v. Rockford Mem'l Corp., 898 F.2d 1278, 1284 (7th Cir. 1990) (Posner, J.); Hosp. Corp. Am. v. FTC, 807 F.2d 1381, 1388 (7th Cir. 1986) (Posner, J.), *aff'ing In re* Hosp. Corp. Am., 106 F.T.C. 361 (1985).

In the future it is likely that the Agencies will have to determine whether certain specialty hospitals should be included in an inpatient product market for particular proposed hospital mergers. Historically, the type of specialty hospital (children's, psychiatric, VA, military, and rehabilitation) justified its exclusion from the product market.[122] In recent years, specialty hospitals focusing on cardiac or orthopedic care have emerged in numerous locations.[123] General acute-care hospitals view these specialty hospitals as competition in the provision of such services and have responded in a variety of ways.[124]

Several panelists discussed an approach for defining an inpatient hospital product market

---

One panelist stated that despite the general acceptance of this definition, both the parties and the courts have suggested subtle differences in the product market definition over the years. Sacher 3/26 at 65; Sacher Presentation, *supra* note 119, at 6-7; Sacher & Silvia, *supra* note 18, at 185-87, *citing Carilion Health Sys*., 707 F. Supp. at 844-45 (noting the district court held product market included certain clinics and other providers of outpatient services, because, in a significant number of cases, "patients or their doctors can choose to have problems treated either in a hospital or in an outpatient clinic or doctor's office"); *Rockford Mem'l*, 898 F.2d at 1284 (excluding outpatient services, and specifically stating that it found the district court's discussion in Carilion "unpersuasive as well as inconsistent with [its] analysis in Hospital Corporation of America" and that the Fourth Circuit's opinion affirming the district court was nonprecedential because the Fourth Circuit chose not to publish it); United States v. Mercy Health Services, 902 F. Supp. 968 (N.D. Iowa 1995), *vacated as moot*, 107 F.3d 632 (8th Cir. 1997) (excluding inpatient psychiatric care, substance abuse treatment, rehabilitation services, and open heart surgery); United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121, 138-40 (E.D.N.Y. 1997) (rejecting DOJ's argument that the relevant product market was "the bundle of acute care inpatient services provided by anchor hospitals to managed care plans," and found separate primary/secondary care and tertiary care product markets based on its conclusion that the geographic markets for these services differed); and FTC v. Tenet Healthcare Corp., 17 F. Supp. 2d 937, 943 (E.D. Mo. 1998), *rev'd* 186 F.3d 1045 (8th Cir. 1999) (product market included primary and secondary acute care inpatient services, but excluded tertiary and quaternary services).

The federal district court in *Carilion* refused to draw a line between inpatient and outpatient services, noting that primary care provided in hospital emergency departments and specialty clinics, as well as hospital-based outpatient surgery, chemotherapy, and radiology may compete to some degree with physicians' office-based care and other free-standing health care. *Carilion Health Sys.*, 707 F. Supp. at 844-45. Other entities may include ambulatory surgical and imaging centers (*e.g.*, x-ray, CT, MRI). *Hosp. Corp. Am.*, 106 F.T.C. 361 (1985); *see also* Sacher 3/26 at 75.

[122] Psychiatric and rehabilitation hospitals provide a limited scope of care and do not offer general acute care services. Children's and VA hospitals provide inpatient acute care similar to general acute care hospitals, but are dedicated to a specific group. Although a children's hospital might compete with a general hospital for a subset of the general hospital's patients, non-veterans cannot substitute the VA for a general hospital. *But see* Eisenstadt 3/28 at 59 (discussing issues about mergers between complements generally and, specifically, a merger between the premier adult hospital system and the premier children's hospital in the Pittsburgh, Pennsylvania area. He noted that although "there would be some modest to slight or slight to modest increase in concentration in pediatrics, that was not the principal concern; rather, the primary concern related to the proposed combination of the preferred adult system and the premium pediatric hospital. In other words, the two premier brand manufacturers were merging. There was concern expressed about post-merger bundling, denial of access to Children's or unilateral price increases" at one or more of the merging hospitals).

[123] *See supra* Chapter 3.

[124] *Id*.

more narrowly. Instead of treating acute inpatient treatment as an aggregated group, panelists suggested the possibility of grouping diagnosis related groups (DRGs) together, based upon the types of diseases and medical conditions treated by particular types of physicians.[125] In one study, this approach resulted in 48 service categories. Patient flow data can be separately analyzed for each category.[126] Panelists recognized, however, that payors generally do not disaggregate services this finely.[127]

Conclusion. The Agencies continue to believe that inpatient acute-care services constitute a relevant product market. At the same time, the percentage of total health care spending devoted to outpatient care is growing, and the percentage devoted to inpatient care is declining. Over time, the level of payment and changes in technology may shift the provision of many inpatient services into the outpatient setting.[128] The Agencies will continue to examine whether services provided in outpatient settings may constitute additional relevant product markets, and if so, whether those services might be adversely affected by a hospital merger. The Agencies will also continue to examine the competitive significance of specialty hospitals, including whether and under what circumstances payors might discipline prices for cardiac or other services at general acute care hospitals by shifting a larger percentage of patients to specialty hospitals that provide such services.

Although the Agencies currently doubt the advisability and practicability of conducting separate product market analyses for many discrete markets – particularly when payors do not define the product they are purchasing in this fashion – the Agencies will continue to examine whether smaller product markets exist in addition to the traditional product market definition. For example, if more specialized medical procedures raise more competitive concerns than primary care services, there may be some circumstances in which the product market should be defined narrowly to include only a specific service or limited number of services. Similarly, it is

---

[125] Sacher 3/26 at 80-83; Sacher & Silvia, *supra* note 18, at 184, 190-98; Zwanziger 3/26 at 95-96; Zwanziger Presentation, *supra* note 34, at 5-7. DRGs are a system for determining hospital compensation based on the discharge diagnosis. Similar illnesses are aggregated together, and the hospital is paid a set amount per DRG, irrespective of the actual cost associated with the provision of services. Medicare and many private insurers use this system to compensate hospitals.

[126] Sacher 3/26 at 80-83; Sacher & Silvia, *supra* note 18, at 184, 190-98.

[127] Panelists noted that payors typically categorize services and hospitals by the complexity of care; some hospitals provide primary, secondary, and tertiary levels of care, others only primary or secondary. Zwanziger 3/26 at 95. One panelist noted that many payors believe they must have at least one tertiary care center in their hospital networks in order to compete for members. Zwanziger 3/26 at 95. Another panelist also noted that properly defining the relevant product market, such as determining whether tertiary care is or is not a part of the relevant market, is a prerequisite to properly defining hospital geographic markets. For example, if tertiary care is excluded from the relevant product market, neither patient flow data or other evidence related to tertiary care is relevant to geographic market definition. *See* Vistnes, *supra* note 35, at 684, 687-88. *See also* Guerin-Calvert 3/26 at 128-29 (discussing differences about geographic market definition often stem from disagreements about the product market definition).

[128] *See, e.g.*, Sacher 3/26 at 75.

possible that expertise in one or more specific specialities may make a hospital a "must have" hospital for a payor's network, which could justify a separate product market analysis.[129]

IV. ENTRY

The *Merger Guidelines* provide that entry should be considered if it is likely to occur within two years and to be sufficient to deter or counteract anticompetitive effects of a proposed hospital merger.[130] Entry into the inpatient general acute care hospital services market by constructing a new hospital or adding additional beds to an existing facility is likely to exceed this time-frame. If the state requires that a Certificate of Need (CON) be granted before building a new hospital or increasing bed capacity, the approval of the CON can take anywhere from 18 months to several years.[131] Compliance with other regulations will require additional time. Thus, the likelihood of timely and sufficient entry into the inpatient general acute care hospital services market is remote.

V. EFFICIENCIES

The *Merger Guidelines* make clear that efficiencies should be evaluated before determining whether a proposed merger is likely to be pro- or anti-competitive.[132] Under the *Merger Guidelines*, the Agencies will not challenge a merger if cognizable efficiencies are of a character and magnitude such that the merger is not likely to be anticompetitive in any relevant market.[133] Efficiencies are cognizable when they are (1) merger-specific, (2) have been verified, and (3) do not arise from anticompetitive reductions in output or service.[134]

Hospitals often claim that their merger will produce significant efficiencies, and some courts have given significant weight to these arguments. Claimed efficiencies have included avoidance of capital expenditures, reductions in management and operational support jobs,

---

[129] *But see* United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121, 138-40 (E.D.N.Y. 1997) (rejecting DOJ's argument that the relevant product market was "the bundle of acute care inpatient services provided by anchor hospitals to managed care plans").

[130] MERGER GUIDELINES, *supra* note 9, § 3.

[131] The FTC has opposed state CON requirements as an unnecessary impediment to competition in health care markets. See discussion *infra* Chapter 8 for a more detailed discussion of CON regulations and the competitive issues surrounding them.

[132] MERGER GUIDELINES, *supra* note 9, § 4 (as revised April 8, 1997).

[133] *Id*. § 4.

[134] Merger-specific efficiencies are "only those efficiencies likely to be accomplished with the proposed merger and unlikely to be accomplished in the absence of either the proposed merger or another means having comparable anticompetitive effects." MERGER GUIDELINES, *supra* note 9, § 4. Cognizable efficiencies are assessed "net of costs produced by the merger or incurred in achieving those efficiencies." *Id*.

consolidation of specific services to one location (*e.g.*, all cardiac care at Hospital A and all cancer treatments at Hospital B), and reducing operational costs, such as purchasing and accounting.

Some hospitals claim that after the merger they will be able to provide better and more complex services to their patients. For example, in *Tenet* the merging hospitals claimed they would realize significant efficiencies, including: eliminating unused beds, bringing open heart surgery to Poplar Bluff, decreasing operating costs, consolidating services, reducing staff levels, and avoiding capital expenditures.[135] The district court rejected the hospitals' efficiency claims. The Eighth Circuit found that, although the district court may have properly rejected the hospitals' efficiencies, it should have nonetheless considered the claim that the merged entity would provide better care to its patients. The appellate court stated that "[t]he reality of the situation in our changing healthcare environment may be that Poplar Bluff cannot support two high-quality hospitals;" and admonished the district court for placing "an inordinate emphasis on price competition."[136]

Some panelists were skeptical about efficiency claims. Several panelists pointed out that promised efficiencies may not materialize.[137] One panelist noted that efficiency studies are often conducted to support the HSR filing that the merging parties must make with the Agencies; this provides incentives for the parties to estimate unrealistically high savings.[138] Another noted that mergers can be great failures if hospitals do not have specific plans or are not willing to make tough decisions at the outset, such as closing facilities and consolidating hospital-based physician groups.[139] Institutional constraints can make it difficult for merged hospitals to

---

[135] FTC v. Tenet Healthcare Corp., 17 F. Supp. 2d 937, 948 (E.D. Mo. 1998), *rev'd on other grnds*, 186 F.3d 1045 (8th Cir. 1999).

[136] *Tenet Healthcare Corp.*, 186 F.3d at 1055, 1054.

[137] *See, e.g.*, Taylor 4/11 at 162-169; Balto 4/11 at 207-210 (noting that Blodgett/Butterworth's claimed efficiencies were mostly in avoidance of capital expenditures, yet the hospitals have made significant capital investments and claim they have achieved $300 million in efficiencies). *See also* Paul Pautler, *Evidence on Mergers and Acquisitions*, 48 ANTITRUST BULL. 119, 160-64, 172-76 (2003) (reviews several studies that looked at post-merger effects on prices and efficiencies, noting one study found that the efficiencies may take a long time to appear and that some studies found cost and price reductions, and others found few efficiencies and significant price increases); David Balto & Meleah Geertsma, *Why Hospital Merger Antitrust Enforcement Remains Necessary: A Retrospective on the Butterworth Merger*, 34 J. HEALTH L. 129 (2001). *But see* Spectrum Health, *Comments Regarding Hearings on Health Care Competition Law and Policy* 1 (Public Comment) (arguing that in connection with the Butterworth/Blodgett merger "[o]perational efficiencies have saved the community $373 million through 2001") [hereinafter Spectrum (public cmt)].

[138] Taylor 4/11 at 162-169.

[139] Hopping 4/11 at 184-86 (she also noted mergers can be successful).

combine and coordinate clinical operations.[140]

For example, in *Butterworth*, the district court accepted the merging hospitals' claims that the proposed merger would result in efficiencies in excess of $100 million in the form of capital expenditure avoidance and operating efficiencies.[141] One panelist reported, however, that Blodgett/Butterworth never closed Blodgett and consolidated services, at least in part because physician groups did not want the facility closed.[142] Another panelist stated that, six years after the merger, Blodgett/Butterworth had realized less than half of the $100 million of claimed efficiencies.[143]

Scholars have conducted numerous studies on the effect of hospital mergers on hospital costs.[144] The results are mixed: some studies have found that merged hospitals enjoy lower costs (or lower rates of cost increase) than nonmerging hospitals; others have found no differences in cost experience between merging hospitals and otherwise similar nonmerging facilities. One recent study found that the degree of cost savings that merging hospitals realize varies significantly depending on the extent of consolidation. According to this study, hospitals operating under a single license post-merger generate "significant, robust, and persistent" savings.[145] In contrast, those hospitals that conduct business under separate licences post-merger do not generate cost reductions. The authors attribute this difference to the ability of more fully merged hospitals to undertake substantial changes in they way they operate (including

---

[140] *See, e.g.*, Balto 4/11 at 209-10 (noting failure to consolidate services at Blodgett/Butterworth because of physician resistance); Hopping 4/11 at 183-90 (noting she has been associated with hospital mergers that have realized efficiencies, but to work, the hospitals must have a specific plan and must be willing to make very hard choices).

[141] FTC v. Butterworth Health Corp., 946 F. Supp. 1285, 1300-1301 (W.D. Mich. 1996), *aff'd by an unpublished opinion*, 1997-2 Trade Cas. (CCH) ¶ 71,863 (6th Cir. 1997) (district court also noted that the efficiencies are, "by any account, a substantial amount, and represent savings that would, in view of defendants' nonprofit status and the Community Commitment, invariably be passed on to consumers").

[142] Balto 4/11 at 209-10.

[143] Taylor 4/11 at 167.

[144] Jeffrey A. Alexander et al., *The Short-Term Effects of Merger on Hospital Operations*, 30 HEALTH SERVICES RES. 827 (1996); Robert A. Connor et al., *Which Types of Hospital Mergers Save Consumers Money?* 16 HEALTH AFFAIRS 62 (Nov./Dec.1997); Robert A. Connor et al., *The Effects of Market Concentration and Horizontal Mergers on Hospital Costs and Prices*, 5 INT'L J. ECON. BUS. 159 (1998); David Dranove & Mark Shanley, *Cost Reductions Versus Reputation Enhancements as Motives for Mergers: The Logic of Multihospital Systems*, 16 STRATEGIC MGMT. J. 55 (1995); David Dranove et al., *Are Multihospital Systems More Efficient?* 15 HEALTH AFFAIRS 100 (Spring 1996); Heather Radach Spang et al., *Hospital Mergers and Savings for Consumers: Exploring New Evidence*, 20 HEALTH AFFAIRS 150 (July/Aug. 2001).

[145] David Dranove & Richard Lindrooth, *Hospital Consolidation and Costs: Another Look at the Evidence*, 22 J. HEALTH ECON. 983, 996 (2003).

consolidation of services) that are not available to hospitals operating under separate licenses.[146]

Even if a hospital merger is likely to create cognizable efficiencies, those cognizable efficiencies likely will not be sufficient to reverse a hospital merger's potential to harm consumers in the relevant market by preventing price increases in that market.[147]

As discussed in detail in Chapter 3, *supra*, most studies of the relationship between competition and hospital prices generally find that increased hospital concentration is associated with increased prices.[148] Some panelists and commentators believe an important motivation for the creation of multi-hospital systems has been to gain market power to secure higher reimbursement from payors.[149] Indeed, one academic health economist reported that "I have asked many providers why they wanted to merge. Although publicly they all invoked the synergies mantra, virtually everyone stated privately that the main reason for merging was to avoid competition and/or obtain market power."[150]

In several merger cases, hospitals have signed "community commitments" or agreements with State Attorneys General, promising not to raise prices for a specified period or to pass onto consumers a specified amount of money from the claimed efficiencies.[151] Some State Attorneys

---

[146] *Id*. Another study similarly found that the impact of hospital mergers on quality differed by type of consolidation. Vivian Ho & Barton H. Hamilton, *Hospital Mergers and Acquisitions: Does Market Consolidation Harm Patients?* 19 J. HEALTH ECON. 767 (2000). Although the authors found no evidence that mergers measurably affect inpatient mortality, they found that post-acquisition, independent hospitals had higher readmission rates for heart attack patients and that post-acquisition, hospital systems discharged newborn babies earlier. *Id.* at 788. *See also* Smith 4/11 at 170-183 (discussing the 1993 consolidation of a 225 bed community hospital, a 325 bed Catholic hospital, and a small Catholic hospital serving several small communities to form Susquehanna Health System. He claimed the consolidated system saved $105 million in costs and returned savings of $117 million to the community and third party payors pursuant to a community commitment. This speaker also attributed many of the cost savings to the extensive consolidation and elimination of duplicative services among the three hospitals, which required compromises by all concerned.).

[147] MERGER GUIDELINES, *supra* note 9, § 4 ("To make [a determination that a merger is not likely to be anticompetitive in any relevant market], the Agency considers whether cognizable efficiencies likely would be sufficient to reverse the merger's potential to harm consumers in the relevant market, *e.g.*, by preventing price increases in that market.").

[148] *See* Chapter 3.

[149] *Id*.

[150] DAVID DRANOVE, THE ECONOMIC EVOLUTION OF AMERICAN HEALTH CARE 122 (2000).

[151] *See* FTC v. Butterworth Health Corp., 946 F. Supp. 1285, 1302 (W.D. Mich. 1996), *aff'd by an unpublished opinion*, 1997-2 Trade Cas. (CCH) ¶ 71,863 (6th Cir. 1997); United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121, 149 (E.D.N.Y. 1997). Other states also have entered into decrees with merging hospitals that provided for some type of community commitment. *See, e.g.*, Wisconsin v. Kenosha Hosp. & Med. Ctr., 1997-1 Trade Cas. ¶71,669 (E.D. Wis. 1996) (consent decree); Pennsylvania v. Capital Health Sys., 1995-2 Trade Cas. ¶71,205 (M.D. Pa. 1995) (consent decree) (court ordered merged hospitals to pass at least 80 percent of the net cost

General have signed these agreements in an attempt to translate merger-induced cost savings into price reductions to consumers. For example, in *Butterworth/Blodgett,* the merging hospitals agreed: (1) to freeze list prices for three years, (2) to freeze prices for managed care plans at pre-merger levels, (3) to limit profit margins by targeting a five-year rolling average for the merged entity that would not exceed the average of Moody's and Standard & Poor's upper quartile profit margin for other national health care providers, (4) to serve the medically needy, and (5) to ensure that the board of the merged entity would continue to reflect the interests of western Michigan.[152] Similarly, the merging hospitals in *Long Island Jewish Medical Center* entered into an agreement with the Attorney General of the State of New York to "pass on to the community cost savings that will be achieved . . . [to] equal 100 million dollars during the five-year period commencing January 1, 1998."[153] The agreement further provided that up to 50 million dollars of the cost savings could be used "to fulfill its mission to provide high quality health care to economically disadvantaged and elderly members of the community."[154]

Community commitments are temporary and may not represent a binding constraint even during the period they are in effect. Furthermore, such commitments do not solve the underlying competitive problem when a hospital merger has changed market circumstances in ways that increase the likelihood that market power will be exercised. Community commitments represent a distinctly regulatory approach to what is, at bottom, a problem of competition – and that problem will remain after the commitment has expired.[155]

The Agencies do not accept community commitments as a resolution to likely

---

savings to consumers); Pennsylvania v. Providence Health Sys., 1994-1 Trade Cas. ¶70,603 (M.D. Pa. 1994) (consent decree). *See also* Eisenstadt 3/28 at 66-68 (describing economic modeling he and others conducted in connection with a Pittsburgh hospital merger that showed the component prices would increase and consumer welfare would decrease, but the community commitment did not address this issue, which in his view was one of the most troublesome aspects of the merger); E. Cooper 9/9/02 at 134 (noting State Attorneys General in Pennsylvania and Wisconsin "have crafted consent agreements that allow the transaction to proceed, but placed restrictions on the merged entity's future conduct. Such restrictions, usually characterized as regulatory by detractors and creative by proponents, typically require the new entry to pass along to consumers cost savings from efficiencies claimed from the merger.").

[152] *Butterworth Health*, 1997-2 Trade Cas. (CCH) ¶ 71,868. *See also Butterworth Health*, 946 F. Supp. at 1304-10; Spectrum (public cmt), *supra* note 137, at 1-7 (noting that they have honored the community commitment they entered in connection with the Butterworth/Blodgett merger).

[153] *Long Island Jewish Med. Ctr.*, 983 F.Supp. at 149.

[154] *Id*.

[155] Sage et al., *supra* note 8, at 42-43; Kursh 10/1 at 89-91; Orlans 10/1 at 91-93. *But see* Donahue 10/1 at 36-44 (Chief Deputy Attorney General, Antitrust Section, Pennsylvania Office of the Attorney General, discussing the pros and cons of regulatory decrees used in connection with three separate hospital mergers in Pennsylvania); Singer 10/1 at 44-45 (suggesting structural relief or blocking the merger is an all-or-nothing solution, but the conduct or regulatory remedy allows a community to realize benefits from the merger, such as efficiencies, and still guard against potential anticompetitive effects).

anticompetitive effects from a hospital (or any other) merger. The Agencies believe community commitments are an ineffective short-term regulatory approach to what is ultimately a problem of competition. Nevertheless, the Agencies realize that in some circumstances, State Attorneys General may agree to community commitments in light of the resource and other constraints they face.

VI. NONPROFIT STATUS OF HOSPITALS

The significance of institutional form (nonprofit v. for-profit) has been an issue in several hospital merger cases. In three early cases, the Seventh and Eleventh Circuit Courts of Appeals rejected the claim that institutional form should figure in a merger analysis. Thus, in *HCA,* the Seventh Circuit noted that although "different ownership structures might reduce the likelihood of collusion, … this possibility is conjectural," and that "adoption of the nonprofit form does not change human nature."[156] Similarly, in *University Health,* the Eleventh Circuit observed that "the Supreme Court has rejected the notion that nonprofit corporations act under such a different set of incentives than for-profit corporations that they are entitled to an implicit exemption from the antitrust laws."[157] Finally, in *Rockford*, the Seventh Circuit repeated and elaborated its position that institutional form was irrelevant to a merger analysis:

> We are aware of no evidence – and the [appellees] present none, only argument – that nonprofit suppliers of goods or services are more likely to compete vigorously than profit-making suppliers . . . . If the managers of nonprofit enterprises are less likely to strain after that last penny of profit, they may be less prone to engage in profit-maximizing collusion but by the same token less prone to engage in profit-maximizing competition.[158]

The relevant question for antitrust analysis is not whether nonprofit hospitals behave in a manner indistinguishable from for-profit institutions, but rather whether they would exploit merger-created market power in ways harmful to consumers.[159] Recently, some courts have asserted that institutional form should matter – and suggested that nonprofit hospitals, even if they acquire market power, will not harm competition or consumers. For example, in *Butterworth,* the district court relied on the nonprofit status of the merging hospitals as a reason why the merger would not have anticompetitive effects, and the Sixth Circuit emphasized this

---

[156] Hosp. Corp. of Am. v. FTC, 807 F.2d 1381, 1390 (7th Cir. 1986).

[157] FTC v. Univ. Health, Inc., 938 F.2d 1206, 1224 (11th Cir. 1991), *citing* Nat'l Collegiate Athletic Ass'n v. Board of Regents, 468 U.S. 85, 100 n.22 (1984).

[158] United States v. Rockford Mem'l Corp., 898 F.2d 1278, 1285 (7th Cir. 1990).

[159] It is immaterial if nonprofit hospitals exploit market power in ways that differ from the ways in which for-profit hospitals would exercise it. The issue is whether market power is exploited.

fact in its opinion affirming the district court.[160]

Similarly, in *Long Island Jewish Medical Center*, the court believed that the merging hospitals were nonprofit organizations that "have a genuine commitment to help their communities," and "community service, not profit maximization, is the hospitals' mission."[161]

The practical significance of a hospital's institutional form has been studied extensively. One panelist (who was an expert for the defendant in the *Butterworth/Blodgett* case) stated that economic incentives made it likely that a typical nonprofit hospital's pricing behavior would differ systematically from that of a typical for-profit hospital.[162]

This panelist argued that a number of studies, including work he had performed, indicated that nonprofits that attain market power behave differently from for-profits when it comes to pricing.[163] This panelist qualified this observation, noting that the observed price effects in these studies are averages and do not predict whether or not a particular nonprofit hospital merger will have an effect on price and do not preclude the possibility of price discrimination against certain customers.[164] Moreover, this panelist acknowledged that the

---

[160] FTC v. Butterworth Health Corp., 1997-2 Trade Cas. (CCH) ¶ 71,863, 71,867-68 (6th Cir. 1997) ("[T]he hospitals' expert witness testified that there would be no economic incentive for the board members of a nonprofit hospital to raise prices above competitive levels when the board members themselves had an interest in maintaining low prices. Because the boards of these hospitals are comprised of community and business leaders whose companies pay the health care costs of their local employees, the district court found that undue price increases were unlikely.").

[161] United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121, 149, 146 (E.D.N.Y. 1997). *See also* Sage 5/29 at 149-50 ("[C]ourts may misperceive antitrust claims involving hospital mergers as calling into question the overall trustworthiness of major community institutions … . [N]onprofit health facilities are widely presumed to be acting in the public interest, and this expectation is an important part of the reason for according them nonprofit status in the first instance. In Butterworth, for example, the court assumed that increased revenue to the merged hospital would be spent by the board of trustees on improving quality and helping the uninsured.").

[162] Lynk 4/10 at 8.

[163] *Id*. at 8, 19-20; William Lynk, *Joint FTC/DOJ Hearings on Health Care and Competition Law and Policy* 1-2 (4/10) (slides) [hereinafter Lynk Presentation], *at* http://www.ftc.gov/ogc /healthcarehearings/docs/030410williamjlink.pdf. Lynk's 1995 study used California data from 1989 and looked at net prices in markets with more or less concentration, specifically controlling for the hospitals' for-profit or nonprofit status, as well as other factors. William J. Lynk, *Nonprofit Hospital Mergers and the Exercise of Market Power*, 38 J.L. & ECON. 437 (1995). Lynk then simulated the price effects of a merger and found that for-profit hospitals had more than an 8 percent increase in price and nonprofit hospitals had a 4.1percent decrease in price. *Id.* at 453. Lynk also referenced and described several other studies. Lynk Presentation, *supra*, at 1-2.

[164] Lynk 4/10 at 8, 20-2121-23; Lynk 4/10 at 11 (noting that different nonprofits can have different incentives; a nonprofit hospital with local governance and control may be aligned more with local community interests than a nonprofit hospital that is part of a larger nonprofit organization that views it as a profit center to support the larger organization's other activities). *See also* Touzin 4/10 at 86-87, 92 (consumer group representative stating that consumers perceive a difference between for-profit and nonprofit hospitals and that conversions of

empirical evidence of a price effect is mixed.[165]

By contrast, several panelists maintained that the best available empirical evidence indicated no significant differences between the pricing behavior of for-profit and nonprofit hospitals.[166] For example, one panelist stated that "the preponderance of the empirical evidence indicates that nonprofit hospitals use their market power in roughly the same fashion as for-profit hospitals."[167] Another panelist similarly reported that the "literature suggests that, on average, nonprofit hospitals do use market power to obtain higher prices."[168]

Recent empirical studies of pricing behavior paint a fairly consistent picture. One study found that there was no significant difference in how for-profit and nonprofit hospitals exerted market power; for-profit hospitals generally had higher prices in 1986, but nonprofits increased their prices faster from 1986 to 1994.[169] A case study of a nonprofit hospital merger in Santa Cruz, California, found significant evidence of post-merger price increases.[170] Another study noted that "the most interesting result for antitrust policy is the finding that nonprofit hospital mergers lead to higher prices, not lower ones, and that the price increases resulting from a nonprofit merger are getting larger over time."[171]

---

hospitals from nonprofit to for-profit status often result in boards comprised of out-of-state entities and the board's concern is its shareholders, not the community in which it is located).

[165] Lynk Presentation, *supra* note 163, at 7-10. We note also that all of the studies cited by the author are now dated; the most recent of these was published in 1991.

[166] *See, e.g.*, Capps 4/10 at 55-56; G. Young 4/10 at 33-37; Fay 4/10 at 24-25; Sloan 4/10 at 57, 65; Gaynor 5/27 at 77 (noting the "bulk of the evidence in my opinion, however, shows that not-for- profits do exercise market power if given the opportunity."); Frank A. Sloan, *Hospital Ownership Conversions* 21 (4/10) (slides) (no evidence of upcoding studied diagnoses following conversion from non-profit to for-profit status), *at* http://www.ftc.gov/ogc/healthcarehearings/docs/030410sloan.pdf; David Dranove & Richard Ludwick, *Competition and Pricing by Nonprofit Hospitals: A Reassessment of Lynk's Analysis,* 18 J. HEALTH ECON. 87 (1998).

[167] Capps Presentation, *supra* note 42, at 19, Capps 4/10 at 55-56.

[168] G. Young 4/10 at 33; Gary Young, *Nonprofit Ownership and Antitrust Policy* 3-4 (4/10) (slides), *at* http://www.ftc.gov/opp/hc/030410garyyoung.pdf.

[169] Robert Connor et al., *The Effects of Market Concentration From Horizontal Mergers on Hospital Costs and Prices*, 5 INT'L J. ECON. BUS. 159 (1998).

[170] Michael Vita & Seth Sacher, *The Competitive Effects of Not-For-Profit Hospital Mergers: A Case Study*, 49 J. INDUS. ECON. 63, 76-77 Tbls. III & IV, 80-82 (2001). An earlier study by different authors found that hospital mergers resulted, on average, in a 5 percent cost savings. Connor et al., *supra* note 169, at 159.

[171] Emmett B. Keeler et al., *The Changing Effects of Competition on Nonprofit and For-Profit Hospital Pricing Behavior*,18 J. HEALTH ECON. 69 (1999). *But see* Lynk 4/10 at 15; Lynk Presentation, *supra* note 163, at 7 (discussing this study's results, but adding that it confirmed a statistically significant differential in price effects of concentration between nonprofit and for-profit hospitals); Elaine Silverman & Jonathan Skinner, *Medicare Upcoding and Hospital Ownership*, 23 J. HEALTH ECON. 369-89 (2004) (finding that between 1989 and 1996, for-

Merger simulation studies have produced a similar picture. One study found nonprofit status did not lead to lower prices in urban markets, but did result in modestly lower prices in rural markets.[172] Other studies found no differences in pricing behavior resulting from institutional status.[173]

One panelist asserted that even if there are no pricing differences between for-profit and nonprofit hospitals, there can be other differences.[174] Nonprofit hospitals may have different long-term missions and have a different level of public accountability because of their long-term community obligations.[175] There is some empirical evidence that institutional status affects the mix of services provided by a hospital.[176]

This panelist also suggested that board members of a for-profit hospital had fiduciary duties to a different group of individuals than would be the case if the hospital was nonprofit.[177] Another panelist responded that "ownership variations are distinctions without a significant difference [and that all hospitals, irrespective of ownership] have the same mission: to provide the highest quality, appropriate medical care possible to the patients they serve, irrespective of

---

profit hospitals upcoded the pneumonia and stroke DRGs for Medicare reimbursement more frequently than not-for-profit and government hospitals).

[172] Capps 4/10 at 50-51; Capps Presentation, *supra* note 42, at 12.

[173] *See* Town & Vistnes, *supra* note 103, at 749-50 (estimating hospital leverage in negotiations with managed care organizations and finding no statistically significant differences between non-profit and for-profit hospitals' pricing behavior); Capps et al., Competition and Market Power in Option Demand Markets (2003) (unpublished manuscript, on file with Commission) (estimating consumers' willingness to pay for the inclusion of specific hospitals in their health plan network, and using price regressions, predicted that leverage effects price and that there is no difference between the behavior of non-profits and for-profits). *See also* Capps 4/10 at 51-56; Capps Presentation, *supra* note 42, at 13-18.

[174] Jacobson 4/10 at 70; Peter D. Jacobson, *Who Owns the Health Care Enterprise: Is the Not-for-Profit Form Obsolete?* 3 (4/10) (slides) [hereinafter Jacobson Presentation], *at* http://www.ftc.gov/ogc/healthcarehearings/docs/jacobson0304.pdf.

[175] Jacobson 4/10 at 71-73; Jacobson Presentation, *supra* note 174, at 4.

[176] *See generally* Jill R. Horwitz, *Why We Need the Independent Sector: The Behavior, Law, and Economics of Not-For-Profit Hospitals*, 50 UCLA L. REV. 1345 (2003).

[177] Jacobson 4/10 at 81-82; Jacobson Presentation, *supra* note 174, at 12 (suggesting that directors of a for-profit entity have a fiduciary duty to maximize shareholder value, while directors of a nonprofit entity have a fiduciary duty to both the facility and to the community, requiring them to balance their margin against their mission). *See also* Roger G. Pariseau, *Comments* (Public Comment) (recommending that all entities involved in health care market should be nonprofit).

the patient's ability to pay for such care."[178] Government statistics indicate that on average, uncompensated care accounts for a similar percentage of total costs at for-profit and nonprofit hospitals.[179]

Although institutional status has loomed large in debates and legal disputes, the best available evidence indicates that nonprofits exploit market power when given the opportunity to do so. Accordingly, the profit/nonprofit status of the merging hospitals should not be considered a factor in predicting whether a hospital merger is likely to be anticompetitive.

VII. GROUP PURCHASING ORGANIZATIONS

A group purchasing organization (GPO) negotiates contracts with vendors of medical supplies on behalf of its members. GPO members include hospitals, nursing homes, home health agencies, and other health care systems. Some Hearing participants and industry commentators assert that GPOs, acting as their members' buying cooperatives, can be tremendous engines of efficiency, allowing medical buyers to pool their purchasing power to lower health care costs.

Nonetheless, others assert that certain GPO contracting practices may raise competitive concerns related to tying, bundling, and exclusive dealing. The Senate Judiciary Committee, through efforts by Chairman Mike DeWine and Ranking Member Herb Kohl of the Antitrust, Competition Policy and Consumer Rights Subcommittee, and the U.S. General Accounting Office have examined this issue in depth,[180] and the issue was an important topic in the Hearings

---

[178] Fay 4/10 at 24-25; Anthony Fay, *FTC/DOJ Hearings on Health Care and Competition Law and Policy Statement of the Federation of American Hospitals – Hospital's Nonprofit Status* 3 (4/10), *at* http://www.ftc.gov/ogc/healthcarehearings/ docs/030410fay.pdf. *See also* Sofaer 5/30 at 201-202 (noting that references to a "managed care revolution" are misnomers, because there has been no managed care, only managed cost, and that although there was concern at one time about for-profit medicine, that really has not been a concern, "primarily because … 'non-profit' facilities in health care often behave so much like for-profit facilities in health care.").

[179] Vogt 9/9/02 at 52 ("[T]he literature is reasonably clear that the not for-profits don't provide very much more charity care, if more charity care at all. In fact, what small difference there is in charity care is accounted for by the location of the not-for-profit hospitals."); *see also* Sloan 4/10 at 57; David A. Hyman, *Hospital Conversions: Fact, Fantasy, and Regulatory Follies,* 23 J. CORP. L. 741 (1998); David Blumenthal & Nigel Edwards, *The Tale of Two Systems: The Changing Academic Health Center,* 19 HEALTH AFFAIRS 86 (May/June 2000); Gabriel Picone et al., *Are For-Profit Hospital Conversions Harmful to Patients and to Medicare?,* 33 RAND J. ECON. 507 (2002).

[180] *See, e.g.*, *Hospital Group Purchasing: Has the Market Become More Open to Competition?: Hearing Before the Subcomm. on Antitrust, Competition Policy and Consumer Rights of the S. Comm. on the Judiciary*, GAO-03-998T, 108th Cong. (2003); *Hospital Group Purchasing: Lowering Costs at the Expense of Patient Health and Medical Innovations?: Hearing Before the Subcomm. on Antitrust, Competition Policy and Consumer Rights of the S. Comm. on the Judiciary*, GAO-02-690T, 107th Cong. (2002); *Group Purchasing Organizations: Use of Contracting Processes and Strategies to Award Contracts for Medical-Surgical Products: Before the Subcomm. on Antitrust, Competition Policy and Consumer Rights of the S. Comm. on the Judiciary*, 108th Cong. (2003) (testimony of U.S. General Accounting Office) [hereinafter GAO Senate Testimony, *Contracting*]; *Group Purchasing Organization: Pilot Study Suggests Large Buying Groups Do Not Always Offer Hospitals Lower Prices: Before the Subcomm. on Antitrust, Competition Policy and Consumer Rights of the S. Comm. on the Judiciary*, 107th Cong.

and the Commission's Health Care Workshop.[181]

In the sections that follow, we explain what a GPO is, describe its role as a purchasing intermediary, and provide an overview of the GPO industry structure. This section then discusses the various organizational structures GPOs may adopt, the potential incentives created by each, and the various contracting practices used by either GPOs or their suppliers and their potential impact on competition.

Finally, this section addresses concerns expressed during the Hearings and elsewhere that *Health Care Statement* 7, which governs GPOs, impedes the Agencies' ability to challenge GPO practices when, and if, they are anticompetitive. For the reasons discussed below, the Agencies believe these concerns are misplaced, and it is not necessary to revise *Health Care Statement* 7.[182] This statement does not provide a safety zone for the specific types of conduct that some commentators have criticized, including tying, bundling, or exclusive dealing. In such situations, the Agencies would analyze the conduct on a case-by-case basis to determine whether it may violate the antitrust laws.

A. What is a GPO?

GPOs are entities that aggregate health care providers' purchasing volume and contracting functions to negotiate discounts with manufacturers, distributors, and other vendors of medical products and services.[183] According to the Health Industry Group Purchasing Association (HIGPA), 96 percent of all acute care hospitals in the United States use the services of a GPO, and on average, hospitals use at least two GPOs.[184] More than 70 percent of hospital

---

(2002) (testimony of U.S. General Accounting Office) [hereinafter GAO Senate Testimony, *Pilot Study*].

[181] *See* Transcript of Health Care Hearings 9/26 at 114-226; Transcript of Health Care Workshop 9/10/02 at 48-140.

[182] *See* discussion *infra* Section E.

[183] *See* Health Industry Group Purchasing Ass'n (HIGPA), *Group Purchasing Organizations* 6 (Public Comment) (submitted by Robert Betz) [hereinafter HIGPA (public cmt)]; HERBERT HOVENKAMP, COMPETITIVE EFFECTS OF GROUP PURCHASING ORGANIZATIONS'(GPO) PURCHASING AND PRODUCT SELECTION PRACTICES IN THE HEALTH CARE INDUSTRY 1 (2002) (prepared on behalf of Health Industry Group Purchasing Association). *See also* American Bar Ass'n, Section of Antitrust Law, *Comments Regarding The Federal Trade Commission's Workshop on Health Care and Competition Law and Policy (Oct. 2002)* 27-34 (Public Comment).

[184] HIGPA (public cmt), *supra* note 183, at 6 (discussing SMG MARKETING GROUP, 2002 SMG MHS/GPO MARKET REPORT1 (2002)). *See also* Robert Bloch et al., *An Analysis of Group Purchasing Organizations' Contracting Practices Under the Antitrust Laws: Myth and Reality* 1 (9/26) (virtually every hospital belongs to at least one GPO) [hereinafter Bloch (stmt)], *at* http://www.ftc.gov/ogc/ healthcarehearings/docs/030926bloch.pdf; GAO Senate Testimony, *Pilot Study*, *supra* note 180, at 5 (reporting that according to survey data from the American Hospital Association, 68 percent of hospitals belonged to GPOs in 2000; according to HIGPA, 96-98 percent of hospitals belonged to a GPO); Bailey 9/10/02 at 48-56 (discussing GAO's pilot study).

purchases are made through a contract negotiated by a GPO.[185]

GPOs negotiate contracts with manufacturers of products that fall into two general categories – commodities and medical devices.[186] Cotton balls, bandages, and linens are examples of commodities for which hospital clinical staffs generally do not have strong preferences about the manufacturer. High technology medical devices such as pacemakers and stents are examples of medical devices for which hospital clinicians may have a preference as to the manufacturer.[187]

GPOs are not wholesalers or distributors, and they do not take possession of, or title to, the products for which they negotiate contracts.[188] Vendors of medical supplies and services generally submit bids to a GPO in response to a "Request For Proposal."[189] One panelist stated that GPOs "simply negotiate a contract with a supplier that all members of the GPO can access. This guarantees the GPO member that it will receive a price no worse than the pre-negotiated price on the GPO contract."[190] Hospitals and other health care providers then purchase products and services directly from the vendor pursuant to the prices and contract terms specified in the GPO's contract with that vendor.[191]

Others note that in many cases, the GPO's contract does not bind the health care providers and they are free to negotiate separately with the vendor.[192] According to one commentator, "GPO members have substantial freedom to purchase alternative products and do

---

[185] HIGPA (public cmt), *supra* note 183, at 6; Bloch (stmt), *supra* note 184, at 1 (citing Muse & Associates, *The Role of Group Purchasing Organizations in the U.S. Health Care System*, at 3 (March 2000)).

[186] GAO Senate Testimony, *Contracting*, *supra* note 180, at 3.

[187] *Id*. at 3-4. According to HIGPA, other products and services purchased through GPOs include pharmaceuticals, dietary resources, telecommunication services, and janitorial supplies. HIGPA (public cmt), *supra* note 183, at 6.

[188] *See* Bloch (stmt), *supra* note 184, at 7; HIGPA (public cmt), *supra* note 183, at 6 ("GPOs do not purchase products or force the purchase of a particular product. Their value is based solely on offering providers access to desired products at reduced prices. Because most hospitals belong to multiple GPOs, each with a unique set of contracts, hospitals have choices – either choosing among GPO contracts or going directly to the supplier to purchase a particular product.").

[189] GAO Senate Testimony, *Pilot Study*, *supra* note 180, at 7; Bloch (stmt), *supra* note 184, at 8.

[190] Bloch (stmt), *supra* note 184, at 7-8.

[191] GAO Senate Testimony, *Pilot Study*, *supra* note 180, at 7.

[192] Bloch (stmt), *supra* note 184, at 8. *See also* HERBERT HOVENKAMP, GROUP PURCHASING ORGANIZATION (GPO) PURCHASING AGREEMENTS AND ANTITRUST LAW 2 (2004) (prepared for the Health Industry Group Purchasing Association) (agreements typically offer buyers a discount in exchange for the buyers' commitment to purchase a minimum percentage of its needs from a specific vendor); GAO Senate Testimony, *Pilot Study*, *supra* note 180, at 5.

so in significant volumes, particularly where the products in question are differentiated."[193]

B. GPO Industry Overview

The Hospital Bureau of New York, established in 1910, is the first known hospital GPO.[194] According to HIGPA, "[f]rom 1974 to 1999, the number of GPOs grew from forty to 633 . . . [and] it is estimated that approximately 200 GPOs contract directly with suppliers, and that twenty-six of these operate on a national level."[195] One commentator asserted that "when markets in this industry are properly defined, no GPO has a market share as high as 20%. Further, there are many GPOs, and hospitals can and do join multiple GPOs or switch memberships."[196]

In contrast, the GAO's pilot study focused on seven national GPOs, each with purchasing volume of more than $1 billion. The GAO stated that the seven GPOs collectively accounted for purchases totaling approximately $43 billion, or "more than 85% of all hospital purchases nationwide made through GPO contracts."[197] Moreover, according to the GAO, the two largest GPOs in its study accounted for approximately 66 percent of total GPO purchasing.[198]

One panelist explained that the numbers may differ depending on the study, the years measured, and whether percentages are based on all hospital purchases or only on hospital purchases made through a GPO.[199] For example, this panelist noted that the largest GPO accounts for 15 percent of total purchases by hospitals, but 30 percent of purchases made by hospitals through a GPO. Similarly, the second largest GPO's market share goes from 12

---

[193] HOVENKAMP, *supra* note 192, at 2.

[194] Bloch (stmt), *supra* note 184, at 3.

[195] *Id*. at 4-5 (also claiming there were approximately 900 GPOs in 2003, although many of these are subsidiaries of "parent" GPOs, and work regionally to recruit hospitals to participate in the contracts negotiated by the parent GPO).

[196] HOVENKAMP, *supra* note 192, at 6. In another paper, HOVENKAMP, *supra* note 183, Professor Hovenkamp reported "the following market shares for the ten largest GPOs, based on 2001 data:" Novation, 14.6%; Premier, 12.5%; AmeriNet, 4.6%; MedAssets, 4.5%; Managed Health, 3.3%; Consort, 2.2%; HealthCare Purchasing Partners, 1.1%; National Purchasing Alliance, 0.7%; AllHealth, 0.6%; and Innovatix, 0.6%. HOVENKAMP, *supra* note 192, at 9-10 & n.7. *See also* Bloch (stmt), *supra* note 184, at 19 (even largest GPO accounts for only 15 percent of total purchase volume of hospital purchases of supplies and equipment).

[197] GAO Senate Testimony, *Contracting*, *supra* note 180, at 4.

[198] *Id*. *But see* MUSE & ASSOCIATES, THE ROLE OF GROUP PURCHASING ORGANIZATIONS IN THE U.S. HEALTH CARE SYSTEM 3 (2000) (prepared for HIGPA) and Bloch (stmt), *supra* note 184, at 1 (GAO's figures are in contrast to their estimates suggesting GPO contracts cover purchases with an annual value of approximately $150 billion).

[199] Bloch 9/26 at 126-27.

percent of all purchases to 25 percent of purchases made through a GPO.[200]

C. Structure and Incentives

The GAO report explained that "GPOs differ in their corporate structures and their relationships with member hospitals."[201] Member hospitals own some GPOs; in other cases, shareholders that are independent of the member hospitals own the GPO.[202] In some instances, suppliers finance GPOs by paying administrative fees that often are calculated as a percentage of each member's purchases of each supplier's products.[203] These fees are designed to "cover [a] GPO's operating expenses and serve[] as its main source of revenue."[204] GPOs may distribute surplus fees to their member hospitals as well.[205] GPOs may be for-profit or nonprofit organizations.

Because of these differing structures, some panelists and commentators question the extent to which GPOs act as the agents of their buyer-members, or as the agents of the sellers that pay the GPOs' administrative fees. Because suppliers pay GPO fees, some worry that GPOs may operate to increase suppliers' revenues – and, correspondingly, GPO fees – rather than to minimize members' purchasing costs.[206]

Some panelists stated that when GPO members play important decision-making roles in the GPO, the GPO may be more likely to act as the agent of its buyer members. As one commentator put it, "[m]any GPOs are owned by their members, who sit on their boards, and are operated as cooperatives. These boards have no interest in procuring overpriced or substandard

---

[200] *Id*.

[201] GAO Senate Testimony, *Pilot Study*, *supra* note 180, at 6.

[202] *Id*.

[203] *Id*. at 8. According to the GAO, the "Social Security Act, as amended in 1986 allows these fees, which would otherwise be considered "kickbacks" or other illegal payments to the GPO." *Id*. *See also* 42 U.S.C. § 1320a-7b(b)(3)(C); 42 C.F.R. 1001.952 (j) (setting forth safe harbor under the Federal anti-kickback statute for certain GPO fees).

[204] GAO Senate Testimony, *Contracting*, *supra* note 180, at 5.

[205] *Id*. at 5 n.5.

[206] *See, e.g.*, Strong 9/26 at 153-54; Bloch 9/26 at 127-30, 134-35; Clark 9/10/02 at 64, 118; Manley 9/10/02 at 69 (all suggesting GPOs are the buyers agent) *but see* Weatherman 9/26 at 180-81; Everard 9/26 at 170; EINER ELHAUGE, THE EXCLUSION OF COMPETITION FOR HOSPITAL SALES THROUGH GROUP PURCHASING ORGANIZATIONS 29-31 (2002); Hilal 9/26 at 143; Nova BioMedical, *Comments Regarding Hearings on Health Care Competition and Policy (Nov. 7, 2003)* 3-5 (Public Comment) (all suggesting concerns that GPOs may be more concerned about suppliers' interests) [hereinafter Nova (public cmt)].

products [on] behalf of their own institutions."[207] Similarly, one CEO stated that in his GPO the buyers

> make all of the [GPO] contracting decisions … [award] all of the contract[s] … decide which suppliers get the contracts, what their compliance requirements are going to be, … [and] the type of contract that's going to be awarded, whether it's a sole source contract, a dual source contract, or a multi-source contract … [and that each health care system] has a seat on [the] Board of Directors … see[s] financial statements every month, … help[s] us set the budget … [and has] a seat on every single contracting body.[208]

Another panelist stated that hospitals in such GPOs have "multiple opportunities through surveys, through advisory boards, advisory groups ... to have input into the suppliers that are selected for contract in [their] group purchasing organization."[209]

Other panelists asserted, however, that some GPOs act as the agents of the suppliers. One panelist asserted that the majority of GPOs "are financed and thereby controlled by large medical product companies rather than by the hospitals they are supposedly the agents for … . Fees and other incentives running from large medical manufacturers to GPOs allow such manufacturers to inappropriately influence the buying policies of the GPOs, because the compensation of most GPO management is almost always based on this fee income rather than on the real savings to hospital members."[210] As a result, another contended, GPOs "are selling protected market share to dominant suppliers in exchange for fees."[211] Such seller payments "may reflect side-payments being made in exchange for the GPOs conferring a de facto exclusivity that enhances the market power of the incumbent device maker."[212]

D. Contracting Practices

At the Hearings, panelists focused a significant portion of the discussion on whether certain GPO contracting practices – principally alleged tying, bundling, or exclusive dealing practices – injure competition. Such contracting practices include allegations that GPOs negotiate sole-source contracts with certain privileged manufacturers; require hospitals to

---

[207] HOVENKAMP, *supra* note 183, at 5.

[208] Strong 9/26 at 154.

[209] Clark 9/10/02 at 64, 118; *see also* Manley 9/10/02 at 69 (noting existence of product "evaluation committees").

[210] Weatherman 9/26 at 180-81; *see also* Nova (public cmt), *supra* note 206, at 3-5.

[211] Everard 9/26 at 170.

[212] ELHAUGE, *supra* note 206, at 29. *See also* Einer Elhauge, *Antitrust Analysis of GPO Exclusionary Agreements (Sept. 26, 2003)* 19 (Public Comment) (prepared on behalf of the Medical Device Manufacturer's Association) [hereinafter Elhauge (public cmt)].

purchase given volumes of certain supplies; bundle contracts that offer price discounts to purchasers of particular product groups; and enter contracts with manufacturers that last five years or more.[213]

GPOs' critics stated that some suppliers, in league with GPOs with sufficiently large market share, can insist upon a variety of anticompetitive GPO contracting practices to exclude rival suppliers from serving the buyers.[214] They argue that such practices can discourage competitors from entering to bring down prices, and can discourage the research and development efforts necessary to produce innovative health care products that may improve on the incumbent's product.[215] Some charge, for example, that "if a large GPO negotiates a sole-source contract with a manufacturer, the contract could cause an efficient, competing manufacturer to lose business and exit from the market and could discourage other manufacturers from entering the market."[216]

Similarly, GPOs' critics challenge hospital "commitments" to purchase a given volume to obtain a better price.[217] According to one panelist, under such a commitment, a hospital that buys an unauthorized product not only loses its better price on the complying product, but also must repay savings earned from having enjoyed that better price for years.[218] Critics also

---

[213] *See, e.g.,* Strong 9/26 at 156 (do not bundle disparate products, but do bundle branded prescription drugs with generics to get discount on branded); *id.* at 157 (generally, five year contracts only used if significant amount of time and money involved in product evaluation); Bloch 9/26 at 127-38 (noting GPOs under attack for various contracting practices and provided his antitrust analysis of these practices); Everard 9/26 at 166 (bundling); *id*. at 168 (even if contract not technically sole-source, hospitals are not really free to purchase elsewhere because they will lose significant discounts); Hilal 9/26 at 143-46 (discussing problems with bundling and large percent of market his company is sometimes locked out of as result of GPO contracting practices); Elhauge (public cmt), *supra* note 212, at 12-13, 20-21 (discussing problems with bundled and loyalty discounts and rebates). *See also* GAO Senate Testimony, *Contracting*, *supra* note 180, at 5-6; Novation, *Comment Regarding Competition Law and Policy & Health Care (Sept. 30, 2002)* 2-4 (Public Comment).

[214] *See, e.g.*, Everard 9/26 at 168 (stating that "manufacturers with market power are able to exclude competitors, in some cases with the GPO support and in some cases without"); Hilal 9/26 at 141 (arguing that GPOs "defend[] market share of existing dominant suppliers" by blocking entrants from serving the medical market); Elhauge (public cmt), *supra* note 212, at 29-31.

[215] *See, e.g.*, GAO Senate Testimony, *Pilot Study*, *supra* note 180, at 1 (noting that "[s]ome manufacturers – especially small manufacturers of medical devices – allege that contracting practices of some large GPOs have blocked their access to hospitals' purchasing decisionmakers [and that this] den[ies] patients access to innovative or superior medical devices").

[216] *See, e.g.*, GAO Senate Testimony, *Contracting*, *supra* note 180, at 6. A sole-source contract, according to the GAO, is one that "give[s] one of several manufacturers of comparable products an exclusive right to sell a particular product through a GPO." *Id*. at 5. *See also* Nova (public cmt), *supra* note 206, at 4-5 (GPOs impede companies such as Nova from introducing new and innovative products into the GPO's member hospitals).

[217] *See* GAO Senate Testimony, *Contracting*, *supra* note 180, at 5.

[218] *See* Holden 9/10/02 at 100-04; *see also* Elhauge (public cmt), *supra* note 212, at 34.

challenge contracts that offer bundled price discounts to purchasers of particular product groups, and contracts of five years or more that "can direct business to manufacturers for an extended period."[219]

The economic literature on tying, bundling, and exclusive dealing practices indicates that they can be efficient, although under certain circumstances they may be harmful to competition.[220] Scholarly legal commentary in recent years also has called into question the anticompetitive explanations for these practices and has focused on efficiencies and the potential welfare-enhancing aspects of these business arrangements.[221] Thus, courts typically engage in a fact-intensive inquiry to evaluate the competitive effects of such tying, bundling, and exclusive dealing claims.

Courts reviewing tying claims generally require that "(1) two separate products or services are involved, (2) the sale or agreement to sell one is conditioned on the purchase of the other, (3) the seller has sufficient economic power in the market for the tying product to enable it to restrain trade in the market for the tied product, and (4) a not insubstantial amount of interstate commerce in the tied product is affected."[222]

Courts reviewing the competitive consequences of exclusive dealing contracts typically analyze factors such as:

---

[219] *See* GAO Senate Testimony, *Contracting*, *supra* note 180, at 6; *see also* Everard 9/26 at 166 (citing "some of the GPO practices that block innovation and … lower costs," such as "supplier paid fees, sole source contracts, high commitment levels, bundling of both products and companies."); Sing 9/26 at 118-25 (summarizing GAO report on GPOs and noting that certain GPO "contracting strategies have the potential to reduce competition" if the GPO or vendor has "a large market share").

[220] *See, e.g.*, Keith N. Hylton & Michael Salinger, *Tying Law and Policy: A Decision-Theoretic Approach*, 69 ANTITRUST L.J. 469 (2001). *But see* Elhauge (public cmt), *supra* note 212, at 1-46 (arguing why GPO contracting practices can be anticompetitive).

[221] *See, e.g.*, Richard A. Posner, ANTITRUST LAW, at 229-32 (exclusive dealing), 251-56 (exclusive dealing), 197-207 (tying), and 234-36 (bundling) (2nd ed. 2001).

[222] ANTITRUST LAW DEVELOPMENTS at 179 & n.998 (citing cases) (5th ed. 2002). The law of bundled discounts is both unsettled and beyond the scope of this report. Only one court of appeals has squarely addressed bundled discounts, most recently in *LePage's, Inc. v. 3M*, 324 F. 3d 141 (3rd Cir. 2003) (en banc), *cert denied*, 2004 U.S. LEXIS 4768 (2004). The Supreme Court denied review after the United States suggested that LePage's was not "a suitable vehicle for providing … guidance" in this area. Brief for the United States as Amicus Curiae, 2004 WL 1205191, 8 (May. 28, 2004). In its brief, the United States stated that "the Third Circuit was unclear as to what aspect of bundled rebates constituted exclusionary conduct" and "provided few useful landmarks on how Section 2 should apply as a general matter in future cases involving bundled rebates." *Id.* at 16. Although the Third Circuit "cited the general principles" set out in *Brooke Group Ltd. v. Brown & Williamson Tobacco Corp.*, 509 U.S. 202 (1993) and other cases, it "failed to explain precisely why the evidence supported a jury verdict of liability in this case, including what precisely rendered 3M's conduct unlawful." *Id.* The brief further noted that "the court of appeals' failure to identify the specific factors that made 3M's bundled discount anticompetitive may lead to challenges to procompetitive programs and prospectively chill the adoption of such programs." *Id.*

> the degree of exclusion flowing from the restraint, its duration and terminability, the percentage of the market foreclosed and other indicia of the likely effect on competitors' ability to operate, the availability of alternative access routes to supplies or customers, rivals' ability to employ countermeasures to defeat the attempted exclusion, and, ultimately, the likely impact of raising rivals' costs on competition in a relevant market, including consideration of any procompetitive justifications.[223]

As a threshold matter, some panelists and commentators questioned whether allegations of exclusive dealing, tying, and bundling are true. For example, one panelist stated that "very few GPO contracts today are, in fact, exclusive," and unlike true exclusive dealing contracts, sole source contracts allow hospitals the freedom to buy from others.[224] Another commentator noted that GPO loyalty rebate programs allow buyers to purchase from rivals offering lower prices.[225] Other panelists noted that many long-term contracts are qualified in that "almost all GPO contracts can be terminated on 60- to 90-days notice."[226]

Some panelists argued that, even if the GPOs were doing what their critics alleged, these contracting practices can actually increase, not decrease, consumer welfare.[227] For example, one source reported that GPOs use the challenged contracting practices "as incentives for manufacturers to provide deeper discounts and for hospital members to concentrate purchasing

---

[223] FTC STAFF REPORT, ENTERING THE 21ST CENTURY: COMPETITION POLICY IN THE WORLD OF B2B ELECTRONIC MARKETPLACES § 3, at 26 (2000) (citations omitted) *at* www.ftc.gov/os/2000/10/ b2breport.pdf. As four Justices stated in a concurring opinion in *Tampa Electric Co. v. Nashville Coal Co.*, 365 U.S. 320, 329 (1961), courts are to weigh "the probable effect of the [exclusive dealing] contract on the relevant area of effective competition, taking into account the relative strength of the parties, the proportionate volume of commerce involved in relation to the total volume of commerce in the relevant market area and the probable immediate and future effects which preemption of that share of the market might have on effective competition therein." *See also* Jefferson Parish Hosp. District v. Hyde*,* 466 U.S. 2, 45 (1984) (O'Connor, J. concurring) (advocating an analysis focused on "the number of sellers and buyers in the market, the volume of their business, and the ease with which buyer and sellers can redirect their purchases or sales to others").

[224] Bloch 9/26 at 132, 129-130; *see also* Strong 9/26 at 160 (noting that, given the lack of "noncompliance" penalties, GPO Consorta's member health care systems "decide who they want to deal with. It's not us that's out calling those shots."). Another panelist questioned the degree of freedom actually offered, *see* Everard 9/26 at 168-69. For a response to that point, *see* HOVENKAMP, *supra* note 183, at 12 (conceding that "purchases made outside of the GPO contracting process will not necessarily enjoy the quantity-generated cost reductions" of GPO purchasing, but "[i]f that were not the case, then the GPO would have no reason for existence"). *See generally id.* at 24-29, for further argument that GPO contract arrangements do not amount to anticompetitive exclusive dealing.

[225] *See* HOVENKAMP, *supra* note 192, at 8-10.

[226] Bloch 9/26 at 132; *see also* Strong 9/26 at 157 (GPO Consorta has "included new technology provisions in all our contracts on a go-forward basis since the inception of our Code of Conduct. It allows us to go outside a contract with a manufacturer for new technology. In virtually all of our contracts, with perhaps one or two exceptions, we have a 90-day termination provision. That allows us to cancel a contract if we can't come to terms and move forward and contract for that new technology.").

[227] Strong 9/26 at 156-57.

volume to obtain better prices."[228]

Some researchers and industry representatives claim that providers who make purchases pursuant to GPO contracts generally save 10 to 15 percent of the price they would otherwise pay.[229] Also, GPO contracts that bundle products can be "simply ways of making products more attractive, effectively cutting price, or reducing costs by disposing of excess inventory."[230]

One panelist asserted that programs that allow suppliers to "reward [buyers'] higher levels of compliance" can be procompetitive "because they're offering increased dividends in exchange for volume," and because they standardize the buyers' products, which "leads to lower inventory costs [and] the ability to standardize patient care, leading to better quality, better staff education and improved safety."[231] This same panelist explained that long-term contracts are sometimes necessary in light of the costs of "large clinical evaluations." He explained the process involved for clinically evaluating a particular product:

> The evaluation took 18 months. Our direct costs were over $150,000 … . We looked at product utilization in over 8,500 surgical cases in 60 of our facilities with over 2,100 surgeons participating. At the end of that evaluation process, our owners said this was too much work to award just a three-year contract … [and] they decided to award a five-year contract.[232]

He further stated that "strong" GPO programs are needed to counter the growing market power of suppliers that have consolidated in recent years.[233] Finally, he also questioned whether the challenged practices could really be injuring the upstream supplier market, citing evidence that the medical device market is flourishing.[234]

---

[228] GAO Senate Testimony, *Contracting*, *supra* note 180, at 5.

[229] HIGPA (public cmt), *supra* note 183, at 7; MUSE & ASSOCIATES, *supra* note 198.

[230] HOVENKAMP, *supra* note 183, at 22.

[231] Strong 9/26 at 160; *see also* HOVENKAMP, *supra* note 183, at 18 (noting importance of "scale economies"); Strong 9/26 at 153 (arguing that the administrative fees that suppliers pay to GPOs are not to buy monopoly power but to "allow[] the supplier to have one contract in the market [and not] hundreds [to make with] individual health care facilities … [and to generate] marketing and contract visibility … contract implementation support [and] contract evaluation").

[232] Strong 9/26 at 158-59.

[233] *Id*. at 163.

[234] Strong 9/26 at 164; *but see* Weatherman 9/26 at 182 (challenging such assertions and noting that "the influence of supplier fees running directly from medical product's vendors to the manager of the GPO buyers completely confounds any such analysis and creates such an appearance of unfairness and corruption as to deter many venture capitalists from funding new innovators in these markets").

Others, however, question GPOs' claimed efficiencies.[235] For example, after a pilot study, the General Accounting Office reported that "GPOs' prices were not always lower and were often higher than prices paid by hospitals negotiating with vendors directly."[236]

According to the GPO industry, GPOs provide additional benefits to their members, including reduced overhead costs for purchasing departments. In addition, GPOs claim to provide "assistance with product-comparison analysis and standardization of products."[237] Through GPOs, members may be able to reduce their supply costs via group purchasing, rebates, and surplus dividend payments.[238]

As one panelist stated, GPOs can not only "eliminate wasteful administrative duplication[,] … they increase competition between rival GPOs, manufacturers and their member hospitals, all of which can translate into lower prices and higher quality for consumers."[239] Moreover, "GPOs assist members in product selection, an activity that would otherwise use up large amounts of member staff time."[240] One estimate suggested that hospitals would spend on average $155,000 per hospital to duplicate the administrative and other

---

[235] *See, e.g.*, Hilal 9/26 at 139 (questioning GPOs' claimed efficiencies); GAO Senate Testimony, *Pilot Study*, *supra* note 180, at 3; Everard 9/26 at 173.

[236] GAO Senate Testimony, *Pilot Study*, *supra* note 180, at 3 (concluding that some hospitals saved as much as 26 percent by purchasing via a GPO contract, and others paid prices as much as 39 percent higher using the GPO contract. The GAO pilot study also found that hospitals with more than 500 beds often obtained better prices on their own, but "small and medium-sized hospitals were more likely to obtain price savings using a GPO contract." *Id. See also* Lynn James Everard, *Health Policy Statement Number Seven And Marketplace Competition In the Health Care Supply Chain: A Market-Based Analysis* 4 (9/26) ("There is no valid proof of the cost savings claims of GPOs."), *at* http://www.ftc.gov/ogc/healthcarehearings/docs/030926everardadd.pdf. *But see* Bloch (stmt), *supra* note 184, at 6 (asserting that the GAO looked at only two products in one city and broad conclusions about cost savings cannot be drawn from such a small sample and that GAO study "failed to consider the fact that hospitals that obtain better pricing outside their GPO often use the GPO contract as a starting point for their negotiations with vendors").

[237] *See* GAO Senate Testimony, *Pilot Study*, *supra* note 180, at 6-7 (citing to GPO officials and a GPO trade organization).

[238] Strong 9/26 at 151-52; *see also* GAO Senate Testimony, *Contracting*, *supra* note 180, at 1 ("By pooling the purchases of these products for their hospital customers, GPOs may negotiate lower prices from vendors (manufacturers, distributors, and other suppliers), which can benefit hospitals and, ultimately, consumers and payers of hospital care (such as insurers and employers).").

[239] Bloch 9/26 at 127; *see also* Heiman 9/26 at 189-92 (citing variety of efficiencies offered by GPOs); HOVENKAMP, *supra* note 183, at 1-2 (noting savings due to GPOs).

[240] HOVENKAMP, *supra* note 183, at 3.

functions GPOs provide.[241]

The structure and incentives of individual GPOs may play an important role in determining the level of efficiencies they obtain. For example, GPOs acting on their members' behalf may strive to achieve efficiencies for the members.[242] Thus, some noted that when the challenged contracting practices are arranged not by one rival manufacturer seeking to foreclose others, but by "a buyer or its agent" – *i.e.*, the buyers or their GPO – "in order to get lower prices from the manufacture[r]," the practices are likely to be pro-competitive.[243]

One panelist suggested this circumstance distinguishes the challenged practices from typical tying and bundling cases.[244] Indeed, another panelist believed that a GPO's refusal to carry a given manufacturer's product likely reflects buyers' skepticism about the manufacturer's claims about its product, not any competitive injury.[245]

By contrast, some commentators suggest that if suppliers control a GPO, the organization may lack the incentive to promote efficiencies for its members. Some panelists suggested that such GPOs may have an incentive to collude with suppliers aiming to injure rival suppliers in a bid to acquire market power over the market for providing goods and services to the buyers.[246]

---

[241] Eugene S. Schneller, The Value of Group Purchasing in the Health Care Supply Chain 6 (2000), *at* http://wpcarey.asu.edu/hap /hap_novation.cfm; *See also* Bloch (stmt), *supra* note 184, at 7 and n.24. *See also* Novation (public cmt), *supra* note 213, at 2 ("[S]tudies show that if GPOs did not exist, the average hospital would pay $353,000 to replicate those purchasing functions.").

[242] *See, e.g.*, Clamp-All Corp. v. Cast Iron Soil Pipe Inst., 851 F.2d 478, 487-88 (1st Cir. 1988) (Breyer, J.) (noting lack of evidence that a standard-setting organization misled "reasonably sophisticated" buyers).

[243] Bloch 9/26 at 134-35; *see also id*. at 129 (distinguishing between "contracts and bundling programs" that buyers initiate, and those that sellers initiate, and noting that the former pose fewer competitive concerns because they are "driven by the economic interest of GPO member hospitals in obtaining lower prices and quality products").

[244] *Id.* at 134-35.

[245] Strong 9/26 at 157-58 (questioning manufacturers' claims that their excluded products are innovative, and trusting "the clinicians and the other product users" to decide that question for themselves); *see also* Goodman 9/10/02 at 85 (noting GPOs' "evidence-based decision making" with respect to new technologies).

[246] *See, e.g.*, ELHAUGE, *supra* note 206, at 30 n. 86 (challenging assumption that because GPOs are buyers' agents, they act as "an ordinary" buyer would, citing literature on agency costs showing that "agents generally always have some incentive to deviate from the interests of their principals").

The buyers themselves also may have an incentive to reach such agreements with suppliers, in exchange for "side payments that split the seller's supracompetitive profits, or special discounts that give the participating buyers market advantages over other buyers and thus enhance the participating buyers' downstream market power." ELHAUGE, *supra* note 206, at 28; *see also* Hilal 9/26 at 147-48 ("GPOs are not really collective bargainers …. [T]hey are, rather, franchisers …. Why would hospitals allow franchisers … [to] make [their] li[ves] harder? Well, perhaps if they're part-owners of the franchising operation, or if the income is excluded from reimbursement computation ….").

Under this theory, the GPOs agree to raise barriers against rival suppliers through contract terms imposing tying, bundling, or exclusive dealing arrangements on the buyers.[247] These terms seek to "exclude rival manufacturers from competing for hospital sales even when the rival products are better or cheaper."[248] Although suppliers do not need GPO support to attempt to exclude their rivals from the downstream market,[249] one panelist suggested that the GPOs can streamline the efforts to exclude.[250]

GPO members may also find it difficult to pursue other means of procuring goods for a variety of reasons. For example, member hospitals may be contractually bound to purchase certain supplies through a given GPO; the efficiencies that GPOs afford may outweigh their anticompetitive costs; member hospitals may enjoy "side-payments or special discounts" that give them private incentives to stay; a race-to-the-bottom effect may persuade a hospital to maintain its special GPO discount so that it does not suffer *vis-a-vis* its rivals; or agency problems that reward hospital administrators for winning short-term price cuts regardless of long-term harms may prevent hospitals from taking action against these anticompetitive practices.[251]

Others counter that GPOs are unlikely to collude with suppliers in this way for long, because buyers unhappy with the anticompetitive results can always leave the GPO for other means of purchasing supplies.[252] One panelist noted that GPOs must compete for hospitals' business and that hospitals "are free to select GPOs that best represent their interests."[253]

---

[247] *See, e.g.*, ELHAUGE, *supra* note 206, at 9-10; Hilal 9/26 at 143 (arguing that once a GPO grants monopoly power to a supplier, a "newcomer" supplier has difficulty entering because "for the new [product] to be offered … the customers would have to be familiar with that product. For them to be familiar with that product, that newcomer must have access to the market," which he argues is impossible because of the GPOs).

[248] ELHAUGE, *supra* note 206, at 1.

[249] *See* Everard 9/26 at 168-69 ("For example, a multi-line supplier might be able to go to a hospital who is considering buying a product from a small company like Applied and say, you know, you might be able to buy that product and you're right, you're free to do it. However, if you choose to buy from that supplier, you're going to lose significant discounts on all the other products that we sell to you. So … the hospital is not really as free as one might think.").

[250] *See* Weatherman 9/26 at 181-82 ("[T]he existence of GPOs makes anticompetitive contracting incredibly easy and efficient for these large manufacturers who would have to negotiate separate contracts with thousands of individual hospitals instead of with three or four large GPOs. So, the GPOs provide a very efficient vehicle for the large manufacturers to throw their weight around in the market.").

[251] *See* ELHAUGE, *supra* note 206, at 36-42.

[252] HOVENKAMP, *supra* note 183, at 23 (arguing that GPOs lack incentives to accept such a "bribe" from suppliers, in part because it risks having GPO members defect to other means of purchasing supplies).

[253] Clark 9/10/02 at 63; *see also* Burns 9/10/02 at 74 (noting existence of competition among GPOs for hospitals' business); Betz 9/10/02 at 108 (same).

E. Statement 7 Does Not Protect Anticompetitive Contracting Practices

Health Care Statement 7 addresses the formation of a GPO. See Box 7-1. Some have proposed altering *Statement* 7, citing to concerns about alleged anticompetitive contracting practices.[254] The Agencies, however, do not believe that it is appropriate or wise to amend *Statement* 7, because the statement and its safety zone thresholds do not prevent and should not be appropriately read as preventing antitrust challenges to any of the alleged anticompetitive contracting practices about which panelists and others have raised concerns.

> ***Box 4-1: Health Care Statement 7.*** This statement provides in part: "The Agencies will not challenge, absent extraordinary circumstances, any joint purchasing arrangement among health care providers where two conditions are present: (1) the purchases account for less than 35 percent of the total sales of the purchased product or service in the relevant market; and (2) the cost of the products and services purchased jointly accounts for less than 20 percent of the total revenues from all products or services sold by each competing participant in the joint purchasing arrangement."

Statement 7 and its safety zone thresholds aim to address monopsony and oligopoly concerns with the formation of a GPO.[255] This statement reflects concerns that a particular GPO could (1) create monopsony power, injuring competition in the supplier market or (2) facilitate collusion in the sale of hospital products or services, injuring competition in the downstream market.

Statement 7 does not address all potential issues that GPOs may raise. For example, it is silent on alleged exclusive dealing, tying, and bundling concerns that many panelists discussed in the Hearings. It is also silent on other potential competitive concerns, such as price-fixing, market allocation, mergers, etc. No statement is likely to cover every issue that could arise. The Agencies believe amending the statement to address some, but not all potential issues, is likely to be counterproductive. For example, some might argue that because certain issues were discussed, *Statement* 7 implicitly endorses as legal whatever conduct is not specifically addressed. If a supplier coordinates with the buyers, or with GPOs that have turned on their

---

[254] *See, e.g.*, Everard 9/26 at 165-66 (stating that *Health Care Statement* 7 does not "protect patients and caregivers" and that "it must be revised to address the economic realities of the current medical product marketplace"); GAO Senate Testimony, *Pilot Study*, *supra* note 180, at 1 (noting that new concerns "have spurred calls for reexamining federal antitrust guidelines regarding GPOs" and stating that the antitrust guidelines "afford[] GPOs considerable latitude to merge and grow [and] has permitted the creation and growth of the largest GPOs"). *But see* Bloch 9/26 at 219-23. (defending *Health Care Statement* 7).

[255] One panelist noted this point and "urg[ed] the FTC to revisit the structure of the guidelines" to make the point clear. Latham 9/10/02 at 93. It is hardly atypical for Agency guidelines to address only a certain class of competitive issues. The Competitor Collaboration Guidelines also address only a limited set of anticompetitive concerns; they were not designed to address all possible anticompetitive conduct associated with competitor collaborations. *See Antitrust Guidelines for Collaborations Among Competitors*, 2 n.5 (2000) *at* http://www.ftc.gov/os/2000/04/ftcdojguide lines.pdf.

buyers, to exclude rival suppliers, *Statement* 7 would not protect such conduct from antitrust challenge.

In sum, *Statement* 7 governs Agency actions examining monopsony and oligopoly issues in connection with a GPO's formation. It does not preclude Agency action challenging anticompetitive conduct – such as anticompetitive contracting practices – that happens to occur in connection with GPOs. The Agencies will examine, on a case-by-case basis, the facts of any alleged anticompetitive contracting practices to determine whether the practice violates the antitrust laws.

VIII. TIERING AND PAY-FOR- PERFORMANCE

Commentators and panelists noted that some providers have resisted tiering and pay-for-performance programs, and refused to provide information regarding the quality of care they provide.[256] When providers collectively refuse to enter into such arrangements or provide information to purchasers, the Agencies will carefully examine such conduct. As appropriate, the Agencies will bring cases against providers who collusively refuse to enter into such arrangements or provide such information. The Agencies also will challenge unilateral conduct or bundled contracting practices, where appropriate.

[256] *See supra* Chapters 1 & 3.